

2195

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 322 N. Potomac St.,		d. STREET ADDRESS 322 N. Potomac St.,	
3. NAME OF DECEASED (Type or print) First Arthur Middle Guy Last Albert		4. DATE OF DEATH Month 2 Day 27 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1877
9. AGE (In years lost birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Hardware merchant	
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rezin Franklin Albert		14. MOTHER'S MAIDEN NAME Hannah E. Buckingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-3098	
17. INFORMANT Mrs. Maggie L. Albert		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 3-1-55		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1-55 , 19____, to 2-27-56 , 19____, that I last saw the deceased alive on 2/26/56 , 19____, and that death occurred at 9:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE PEARL YOUNG		ADDRESS (Street, city or town, state) Hagerstown, Md.	
PHYSICIAN'S NAME (Type) PEARL YOUNG		DATE SIGNED 2/27/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-29-56	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Feb. 29, 1956		24b. REGISTRAR'S SIGNATURE Charles Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Reg. Dist. No.

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1890		New York City		New York City		Heart Disease		Jan 15, 1935		10:00 AM		Home		J. Smith, M.D.		A. B. Jones	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Medical History		Treatment		Burial Place		Burial Date		Burial Time		Burial Place	
Teacher		Married		White		Roman Catholic		High School		None		None		None		Catholic Cemetery		Jan 16, 1935		11:00 AM		Catholic Cemetery	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Mortician		Signature of Embalmer		Signature of Funeral Home		Signature of Cemetery		Signature of Church		Signature of Burial Society	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

MAR 5 1935

RECEIVED

2247

CERTIFICATE OF DEATH

Reg. Dist. No. 305.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>WASHINGTON</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>BURNS BOITO</u>	<u>3 WEEKS</u>	OR TOWN <u>FREDERICK</u>	<u>10-11-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>90 REEDER'S NURSING HOME</u>		<u>234 S. MARKET ST.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>MAUDE</u>	(Middle) <u>IRENE</u>	(Last) <u>ALEXANDER</u>	OF DEATH: <u>FEB 9, 1956</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>25 JULY 1889</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>66-6-14</u> yrs.		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>HOUSE-WORK</u>		<u>AT-HOME</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>THOMAS SPONERLER</u>		<u>MARY KRETZER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>NONE</u>	
17. INFORMANT & ADDRESS:			
<u>MISS. MARY ALEXANDER</u>		<u>234 S. Market St. Frederick, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
450.0 IMMEDIATE CAUSE			
(A) <u>Generalized arteriosclerosis</u>			<u>8 yrs.</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 20, 1956</u> , to <u>Feb 9, 1956</u> , that I last saw the deceased alive on <u>Feb 8, 1956</u> , and that death occurred at <u>12:55 P.</u> from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<u>G. W. Livan</u>		<u>Burns Boito</u>	
M. D.		DATE SIGNED	
		<u>2/11/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>12 Feb 1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mt. Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Feb. 11. 1956</u>		<u>John H. Bart.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>M. R. Elchman & Son</u>		<u>Frederick, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2248
CERTIFICATE OF DEATH

02190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrotts mills c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrotts Mills d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Cleveland Last Badger		4. DATE OF DEATH Month 2 Day 23 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1885
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY B and O.R.R.	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel J. Badger	
14. MOTHER'S MAIDEN NAME Mary C. Mc Gaha		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or date of service)	
16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mrs. Isabelle Badger, Knoxville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X Hypertension - st. kidney DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 yr.?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1956 to 2-23-1956 , that I last saw the deceased alive on 2-23-1956 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 2-24-56			
ACTUAL SIGNATURE C. E. Pruitt M.D.		PHYSICIAN'S NAME (Type) C. E. Pruitt	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-26-1956	22c. NAME OF CEMETERY OR CREMATORY Brethern	22d. LOCATION (City, town, or county) (State) Brownsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Futa ADDRESS Brunswick, Maryland		24a. RECEIVED BY REGISTRAR Feb. 28, 1956	24b. REGISTRAR'S SIGNATURE Mrs. Lathin Agerheart

CERTIFICATE OF DEATH

3248

BUREAU V. S.

FEB 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

02191

2411 N. Charles Street, Baltimore

2249

CERTIFICATE OF DEATH

Reg. Dist. No. 905

1. PLACE OF DEATH - COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BENEVOLE		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN IDAMSVILLE - RURAL/OK-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS BOONSBORO MD. R. 1		STREET ADDRESS IDAMSVILLE MD. R.F.D.	
3. NAME OF DECEASED (First) (Middle) (Last) LUTHER - HENRY - BAKER		4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY - 10 - 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPT-27-1919
9. AGE last birthday 36-4-13 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY TENANT	
11. BIRTHPLACE (State or foreign country) BENEVOLE WASH. Co. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HUBERT BAKER		14. MOTHER'S MAIDEN NAME MARY EASTERDAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-34-0639	
17. INFORMANT AND ADDRESS MRS. MARIE BAKER - BOONSBORO MD. R. 1			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Coronary Thrombosis - Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH Instant.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb-10, 1956, to Feb-10, 1956, that I last saw the deceased alive on Feb-10, 1956, and that death occurred at 4:45 A.M., from the causes and on the date stated above.			
SIGNATURE W. L. Lukan		ADDRESS Boonsboro.	
DATE SIGNED 7/11/56			
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF FEB. 13, 1956	
NAME OF CEMETERY OR CREMATORY BENEVOLE CEMETERY		LOCATION (City, town, or county) (State) BENEVOLE WASH. Co. MD.	
DATE REC'D BY LOCAL REG. Feb. 13, 1956		REGISTRAR'S SIGNATURE John N. Reed	
24. FUNERAL DIRECTOR WM. F. BAST AND SONS		ADDRESS BOONSBORO MD	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P. LEVAN

RECEIVED

FEB 15 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2196

CERTIFICATE OF DEATH

Reg. Dist. No.

021924C

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EXXETER HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John James Barnes</u>				4. DATE OF DEATH <u>February 24</u> 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1880</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Preacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Harriett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Auto licence and personal papers</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Chronic nephritis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral concussion. Fracture, left femur.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident 11:30 PM 2-22-56</u>					
20c. TIME OF INJURY Hour a. m. <u>11:30 PM</u> Month, Day, Year <u>2-22 1956</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md.</u>				
21. I certify that I attended the deceased from <u>2-23-56</u> , 19 <u>56</u> , to <u>2-24-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-24</u> , 19 <u>56</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.							DATE SIGNED <u>2-25-56</u>
ACTUAL SIGNATURE <u>John H. Kehne</u>		M.D. _____		ADDRESS (Street, city or town, state) <u>131 W. Washington St., Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN H. KEHNE, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 1, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooks Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Co., Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home-1631 Druid Hill</u>		ADDRESS <u>1631 Druid Hill</u>		24a. RECEIVED BY REGISTRAR <u>MAR 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Brown</u>	

BUREAU V. S.

MAR 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
 2250 CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02193

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wash	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middleburg		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middleburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) (Last) Barr		4. DATE OF DEATH (Month) Feb. (Day) 22 (Year) 1956	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH
9. AGE last birthday 73 yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Penna
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Barr	
14. MOTHER'S MAIDEN NAME Abbie Myers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY No. -		17. INFORMANT AND ADDRESS Flora Barr - Waynesboro, Pa.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
932.0 Immediate cause (a) Exposure to cold - 18 - 20 degrees			10 hrs
Antecedent cause(s) (b) Arterio-sclerotic myocardial heart disease			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Lg. Substernal Thyroid			
Cystic disease of liver & pancreas			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mentally ill			
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION -	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Home	(CITY OR TOWN) (COUNTY) (STATE) Wash Md
TIME (Month) (Day) (Year) (Hour) OF INJURY Feb. 22 - 56 10 P.m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? Found dead on floor of unheated shack	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE S. Robert Wells M.D.		DATE SIGNED 2-24-56	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Feb. 26 '56	NAME OF CEMETERY OR CREMATORY Price Cemetery
LOCATION (City, town, or county) (State) Wash. Twp. Franklin Co Pa.		24. FUNERAL DIRECTOR Scott & Minnick & Son - Hagerstown, Md.	
DATE REC'D BY LOCAL REG. Feb. 24, 1956		REGISTRAR'S SIGNATURE G. H. Bowers	

RECEIVED

FEB 27 1956

BUREAU V. E.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02194

Dr. E.W. Ditt

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>3 days</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>603 Wise Street</u>			
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> <u>FREDERICK</u> <u>BARR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 31</u> <u>19</u> <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 6, 1886</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter Contractor Self-Empl.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank M. Barr</u>				14. MOTHER'S MAIDEN NAME <u>Katie Oster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>242-24-6619 A</u>		17. INFORMANT & ADDRESS <u>Miss Lula Barr</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Vascular Disease</u>				<u>3 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-1-1955</u> , to <u>2-21-1956</u> , that I last saw the deceased alive on <u>2-20-1956</u> , and that death occurred at <u>2-21</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. W. Ditt</u>				ADDRESS (Street, city, town, state) <u>Hagerstown, Md.</u>		DATE SIGNED <u>2/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-23-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Feb 23, 1956</u>		REGISTRAR'S SIGNATURE <u>Blair Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffran-Hagerstown, Md.</u>		ADDRESS	

This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Bureau of Health Statistics of the Maryland State Department of Health, Baltimore, Md.
 In testimony whereof, the seal of the Bureau is hereunto set at the City of Baltimore, Maryland, this 27th day of February, 1956.
 Director

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1519

2187

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		BIRTH DATE [Faint text]		BIRTH PLACE [Faint text]	
MARRIAGE [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. 2

FEB 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02195
2198 CERTIFICATE OF DEATH

Reg. Dist. No. 302....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>03 TOWN Hagerstown</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> <u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81 Wash. Co. Hospital</u>		STREET ADDRESS (If rural give location) <u>626 Potomac Avenue</u>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Edna</u>	(Middle) <u>Adele</u>	(Last) <u>Beck</u>	(Date) <u>Feb. 2</u> (Year) <u>19 56</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 29, 1889</u>
9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR <u>0</u> Months <u>4</u> Days	IF UNDER 24 HRS. <u>0</u> Hours <u>0</u> Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>LaCrosse, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME: <u>D. Edwin Baker</u>	14. MOTHER'S MAIDEN NAME: <u>Lavinia Landis</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)	16. SOCIAL SECURITY No. <u>NONE</u>	17. INFORMANT & ADDRESS: <u>William G. Beck, Hagerstown, Maryland</u>
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18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
330X IMMEDIATE CAUSE	(A) <u>Subarachnoid hemorrhage</u>	<u>21 days</u>
ANTECEDENT CAUSE (S)	(B) <u>Arteriosclerosis</u>	<u>Yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Duodenal Ulcer</u>		<u>5 yrs.</u>
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19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan. 12, 1956 to Feb. 2, 1956, that I last saw the deceased alive on Feb. 1, 1956, and that death occurred at 7:15 AM, from the causes and on the date stated above.

SIGNATURE <u>Clara C. Hoffman</u>	DATE <u>2-5-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
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DATE REC'D BY LOCAL REGISTRAR <u>Feb 5, 1956</u>	REGISTRAR'S SIGNATURE <u>Clara C. Hoffman</u>	24. FUNERAL DIRECTOR <u>Suter-Rouzer Funeral Home, Hagerstown, Md</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2251

CERTIFICATE OF DEATH

02196

Reg. Dist. No. 366

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X JUC-TOWN - RURAL</u> c. LENGTH OF STAY IN lb <u>14 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00 HAGERSTOWN MD. 121</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JUC-TOWN - RURAL X</u> d. STREET ADDRESS <u>HAGERSTOWN MD. R. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES - LEWIS - BISER</u> First Middle Last 4. DATE OF DEATH <u>FEBRUARY-23-</u> 1956 Month Day Year				5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE-6-1891</u> 9. AGE (In years last birthday) <u>64-8-17</u> yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>W. M. R. R. CO.</u> 11. BIRTHPLACE (State or foreign country) <u>FREDERICK CO. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>EDWARD BISER</u> 14. MOTHER'S MAIDEN NAME <u>SARAH DLAUDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>705-10-7046</u> 17. INFORMANT <u>MRS. MARY V. BISER</u> Address <u>HAGERSTOWN MD. 121</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/20</u> , 19 <u>54</u> , to <u>2/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/21</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>Smithsburg, Md.</u> DATE SIGNED <u>2/23/56</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LITTLESTOWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LITTLESTOWN WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. F. BAST AND SONS</u> ADDRESS <u>BOONSBORO MD</u>				24a. REC'D BY REGISTRAR <u>2-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Geo W Fugman</u>	

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Signature. The form is mostly blank with some faint markings.

BUREAU V. S.

FEB 27 1956

RECEIVED

54-21-12-11

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02197

2199

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>522 West Church Street</u>		STREET ADDRESS (If rural give location) <u>522 West Church Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHRISTIAN ALBERT BRECHBILL</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 9</u> 19 <u>56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>January 15, 1889</u>
9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chief Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Milk Company</u>	
11. BIRTHPLACE (State or foreign country): <u>Greenville, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Abram Brechbill</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Lowry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-3188</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Homer Bowser Waynesboro, Pennsylvania</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Coronary Occlusion 1st attack</u> DUE TO			<u>1 year</u>
ANTECEDENT CAUSE (S) (B) <u>Coronary Occlusion 2nd attack</u> DUE TO			<u>1 day ago</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Am</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1st</u> , 19 <u>55</u> , to <u>Feb 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 Feb</u> , 19 <u>56</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. J. Lusby</u>		DATE SIGNED <u>9 Feb 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
DATE THEREOF <u>2/11/1956</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 11, 1956</u>		REGISTRAR'S SIGNATURE <u>Homer Bowser</u>	
24. FUNERAL DIRECTOR <u>Suter-Rouzer Funeral Home</u>		ADDRESS <u>Hagerstown, Mary.</u>	

BUREAU V. S.

FEB 14 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02198

Dr William Layman

2200

CERTIFICATE OF DEATH

Reg. Dist. No. 362

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 Week</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>				STREET ADDRESS (If rural give location) <u>1911 Virginia Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>CLARENCE EDGAR BREWER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 15 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 29 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Protection Fairchild Air Craft Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George M. Brewer</u>				14. MOTHER'S MAIDEN NAME <u>Susan Glass</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-1691</u>		17. INFORMANT & ADDRESS <u>Mrs Hazel M. Brewer</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
180X IMMEDIATE CAUSE (A) <u>Epithelial Carcinoma lungs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 Months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Epithelial Carcinoma of Left Renal Pelvis</u>						Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Atherosclerotic heart disease with old</u>							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION <u>myocardial infarct due to thrombosis -40Months</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 1945</u> , to <u>Feb. 15, 1956</u> , that I last saw the deceased alive on <u>Feb. 14, 1956</u> , and that death occurred at <u>5:55A</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. T. Layman, Md.</u>		M.D.		ADDRESS (Street, city, town, state) <u>5 Public Sq., Hagerstown, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
24. REC'D BY REGISTRAR <u>Feb. 17, 1956</u>		REGISTRAR'S SIGNATURE <u>B. H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md</u>	

BUREAU V. S.

FEB 20 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr W. D. Campbell 02199

2201 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>8 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>				STREET ADDRESS (If rural give location) <u>806 Dale St</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY CATHERINE BROWN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 17 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 5 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Winchester Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John C. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>William Edw Brown</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Chagotian Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio Vascular Disease</u>				<u>5-6 Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 8</u> , 19 <u>56</u> , to <u>Feb 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>56</u> , and that death occurred at <u>4:20 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W D Campbell</u>				DATE SIGNED <u>Feb 18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Hebron Cemetery</u>		LOCATION (City, town, county) (State) <u>Winchester Frederick Co Va.</u>	
24. REC'D BY REGISTRAR DATE <u>Feb 20, 1956</u>		REGISTRAR'S SIGNATURE <u>Chas H Rovers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			
				ADDRESS <u>Hagerstown Md</u>			

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: _____

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. DATE OF DEATH: _____

9. PLACE OF DEATH: _____

10. SIGNATURE OF PHYSICIAN: _____

11. SIGNATURE OF REGISTRAR: _____

12. SIGNATURE OF WITNESS: _____

13. SIGNATURE OF DECEASED: _____

14. SIGNATURE OF NEXT OF KIN: _____

15. SIGNATURE OF CLERGYMAN: _____

16. SIGNATURE OF CHURCH: _____

17. SIGNATURE OF FUNERAL HOME: _____

18. SIGNATURE OF BURIAL PLACE: _____

19. SIGNATURE OF CEMETERY: _____

20. SIGNATURE OF INTERVIEWER: _____

21. SIGNATURE OF INTERVIEWER: _____

22. SIGNATURE OF INTERVIEWER: _____

23. SIGNATURE OF INTERVIEWER: _____

24. SIGNATURE OF INTERVIEWER: _____

25. SIGNATURE OF INTERVIEWER: _____

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39. SIGNATURE OF INTERVIEWER: _____

40. SIGNATURE OF INTERVIEWER: _____

41. SIGNATURE OF INTERVIEWER: _____

42. SIGNATURE OF INTERVIEWER: _____

43. SIGNATURE OF INTERVIEWER: _____

RECEIVED
FEB 23 1956
BUREAU V. S.

RECEIVED

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. DATE OF DEATH: _____
9. PLACE OF DEATH: _____
10. SIGNATURE OF PHYSICIAN: _____
11. SIGNATURE OF REGISTRAR: _____
12. SIGNATURE OF WITNESS: _____
13. SIGNATURE OF DECEASED: _____
14. SIGNATURE OF NEXT OF KIN: _____
15. SIGNATURE OF CLERGYMAN: _____
16. SIGNATURE OF CHURCH: _____
17. SIGNATURE OF FUNERAL HOME: _____
18. SIGNATURE OF BURIAL PLACE: _____
19. SIGNATURE OF CEMETERY: _____
20. SIGNATURE OF INTERVIEWER: _____
21. SIGNATURE OF INTERVIEWER: _____
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41. SIGNATURE OF INTERVIEWER: _____
42. SIGNATURE OF INTERVIEWER: _____
43. SIGNATURE OF INTERVIEWER: _____

1

INSTRUCTIONS

1 executed within **24 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02200

2202

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown, Md.</u>		<u>45 yrs.</u>		TOWN <u>Hagerstown, Maryland.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>460 Summans Ave</u>				STREET ADDRESS (If rural give location) <u>460 Summans Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Alexander Allen Burns</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2 18 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1883 June 27 1909</u>	9. AGE last birthday <u>73 yrs.</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Martinburg, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robert Burns</u>				14. MOTHER'S MAIDEN NAME <u>Unknow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-1402</u>		17. INFORMANT & ADDRESS <u>Mrs Gertrude Burnett 460 Sumans</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/17/56</u> to <u>2/18/56</u> , that I last saw the deceased alive on <u>2/18/56</u> , 19 <u>56</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John H. Young</u>				ADDRESS (Street, city, town, state) <u>William Street</u> DATE SIGNED <u>2/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-22-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland.</u>	
24. REC'D BY REGISTRAR <u>Feb 22, 1956</u>		REGISTRAR'S SIGNATURE <u>Charles H. Powers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson</u>		ADDRESS <u>g. Hagerstown md</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Cohen

02201

2203

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>2 Yrs</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Wash. County Home</u>				<u>900 Concord St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>ANDY</u> (First) <u>-----</u> (Middle) <u>CARACE</u> (Last)				<u>Feb 25 1956</u> (Month) (Day) (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Jan 15 1866</u>	<u>90</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Track Man W M R R</u>		<u>Retired</u>		<u>Austria</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>No Record</u>				<u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mrs Rose C. Cordelli</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>443X</u> IMMEDIATE CAUSE (A) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>				<u>901 Concord St City</u> INTERVAL BETWEEN ONSET AND DEATH <u>7</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>NONE</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>NONE</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>NOV 1 19 56</u> <u>FEB 25 19 56</u> , that I last saw the deceased alive on <u>FEB 23 19 56</u> , and that death occurred at <u>2-20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Andrew Robert Cohen</u> M.D.				ADDRESS (Street, city, town, state) <u>CLEAR SPRING, MD.</u> DATE SIGNED <u>2/27/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/28/56</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown Wash Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 28/1956</u>		<u>Wesley H. Bowers</u>		<u>Andrew K. Coffin</u>		<u>Hagerstown Md</u>	

CERTIFICATE OF DEATH

2003

Form 100-1

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Signature of witness

13. Signature of funeral director

14. Signature of undertaker

15. Signature of cemetery

16. Signature of burial place

17. Signature of interment

18. Signature of cremation

19. Signature of disposition

20. Signature of final disposition

21. Signature of final disposition

22. Signature of final disposition

23. Signature of final disposition

24. Signature of final disposition

25. Signature of final disposition

26. Signature of final disposition

27. Signature of final disposition

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45. Signature of final disposition

46. Signature of final disposition

47. Signature of final disposition

HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE

NAME

HOME

BUREAU V. S.

MAR 2 1956

RECEIVED

CLEAR SPRING, N.H.

2204

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>30 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>718 Forrest Street</u>		STREET ADDRESS (If rural give location) <u>718 Forrest Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>SAMUEL HENDRICKS CONRAD</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 14 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>February 18, 1876</u>
9. AGE last birthday <u>79 yrs.</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u>26</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Shipping Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Dept. Store</u>	11. BIRTHPLACE (State or foreign country): <u>Huyetts, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Benjamin F. Conrad</u>	
14. MOTHER'S MAIDEN NAME: <u>Martha Rummel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>214-09-7618</u>		17. INFORMANT & ADDRESS: <u>Mrs. Mary E. Conrad Hagerstown, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardio-vascular disease</u>			<u>6 yrs</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1-1950</u> , to <u>2-14-1956</u> , that I last saw the deceased alive on <u>2-13-1956</u> , and that death occurred at <u>4⁰⁰</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Robert P. Conrad, M.D.</u>		DATE SIGNED <u>2-14-56</u>	
ADDRESS <u>Hagerstown, Md.</u>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/16/1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 15, 1956</u>		REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	
24. FUNERAL DIRECTOR <u>Suter-Rouzer Funeral Home</u>		ADDRESS <u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02203

2205

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md.		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Hagerstown		LENGTH OF STAY (In this place) 2 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital				STREET ADDRESS (If rural give location) 631 Frederick St.,			
3. NAME OF DECEASED: (Type or Print)		(First) Samuel		(Middle) H		(Last) Cox	
4. DATE OF DEATH:		(Month) 2		(Day) 6		(Year) 19 56	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Dec. 6, 1902	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer		10B. KIND OF BUSINESS OR INDUSTRY: self employed		11. BIRTHPLACE (State or foreign country): Washington Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Cox				14. MOTHER'S MAIDEN NAME: Sarah Santman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unk.): no		16. SOCIAL SECURITY NO. 220-10-3590		17. INFORMANT & ADDRESS: Mrs. Anna M. Cox Hagerstown, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) carcinomatosis originating in							
ANTECEDENT CAUSE (B) stomach.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19A. DATE OF OPERATION: Nov. 17, 1955.		19B. MAJOR FINDINGS OF OPERATION: carcinoma stomach, omentum + liver.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 9, 1955 , to Feb. 6, 1956 , that I last saw the deceased alive on Feb. 5, 1956 , and that death occurred at 5:00 AM , from the causes and on the date stated above.							
SIGNATURE R. Bell		ADDRESS Hagerstown, Md.		DATE SIGNED Feb. 8, 1956		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-9-56		NAME OF CEMETERY OR CREMATORY Rose Hill		LOCATION (City, town, or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR Feb. 8, 1956		REGISTRAR'S SIGNATURE Chas. Bowers		24. FUNERAL DIRECTOR Fred W. Kraiss		ADDRESS Hagerstown, Md.	

BUREAU V. S.

FEB 14 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2206

CERTIFICATE OF DEATH

02204

Reg. Dist. No. 302

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY WASHINGTON	MARYLAND	STATE PENNSYLVANIA	COUNTY FRANKLIN
CITY (If outside corporate limits, write RURAL and give nearest town) GREENCASTLE	LENGTH OF STAY (In this place) 2 WKS.	CITY (If outside corporate limits, write RURAL and give nearest town) GREENCASTLE	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS GARLOCK MEM. CONV. HOSP.		STREET ADDRESS LINDEN AVE.	(If rural give location)
3. NAME OF DECEASED (Type or Print) JOSEPH (First) B. (Middle) CRUNKILTON (Last)		4. DATE OF DEATH FEB. 21 19 56 (Month) (Day) (Year)	
5. SEX MALE	6. COLOR OR WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 6/4/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMP.	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME JOSEPH CRUNKILTON		14. MOTHER'S MAIDEN NAME ELIZABETH DALEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT & ADDRESS MRS. ANN J. SELLERS GREENCASTLE PENNA.
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) Arterio sclerotic heart disease			5 yrs +
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Hemorrhage			1 day
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work Not while at work	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 7 Feb, 1956, to 21 Feb, 1956, that I last saw the deceased alive on 21 Feb, 1956, and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
SIGNATURE F. F. Lusby		DATE SIGNED 2-21-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/24/56	NAME OF CEMETERY OR CREMATORY SHANK CEMETERY
24. REC'D BY REGISTRAR DATE Feb. 23, 1956		REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. E. Minnich, Greencastle Pa.

CERTIFICATE OF DEATH

Reg. No. 101

1. DECEASED PERSON'S NAME (Last, first, middle)

2. DECEASED PERSON'S SEX (Male or Female)

3. DECEASED PERSON'S AGE (Years, months, days)

4. DECEASED PERSON'S OCCUPATION

5. DECEASED PERSON'S PLACE OF BIRTH

6. DECEASED PERSON'S DATE OF BIRTH

7. DECEASED PERSON'S PLACE OF DEATH

8. DECEASED PERSON'S DATE OF DEATH

9. DECEASED PERSON'S CAUSE OF DEATH

10. DECEASED PERSON'S PLACE OF INTERMENT

11. DECEASED PERSON'S DATE OF INTERMENT

12. DECEASED PERSON'S PLACE OF INTERMENT

13. DECEASED PERSON'S DATE OF INTERMENT

14. DECEASED PERSON'S PLACE OF INTERMENT

15. DECEASED PERSON'S DATE OF INTERMENT

16. DECEASED PERSON'S PLACE OF INTERMENT

17. DECEASED PERSON'S DATE OF INTERMENT

18. DECEASED PERSON'S PLACE OF INTERMENT

19. DECEASED PERSON'S DATE OF INTERMENT

20. DECEASED PERSON'S PLACE OF INTERMENT

21. DECEASED PERSON'S DATE OF INTERMENT

22. DECEASED PERSON'S PLACE OF INTERMENT

23. DECEASED PERSON'S DATE OF INTERMENT

24. DECEASED PERSON'S PLACE OF INTERMENT

25. DECEASED PERSON'S DATE OF INTERMENT

26. DECEASED PERSON'S PLACE OF INTERMENT

27. DECEASED PERSON'S DATE OF INTERMENT

28. DECEASED PERSON'S PLACE OF INTERMENT

29. DECEASED PERSON'S DATE OF INTERMENT

30. DECEASED PERSON'S PLACE OF INTERMENT

31. DECEASED PERSON'S DATE OF INTERMENT

32. DECEASED PERSON'S PLACE OF INTERMENT

33. DECEASED PERSON'S DATE OF INTERMENT

34. DECEASED PERSON'S PLACE OF INTERMENT

35. DECEASED PERSON'S DATE OF INTERMENT

36. DECEASED PERSON'S PLACE OF INTERMENT

37. DECEASED PERSON'S DATE OF INTERMENT

38. DECEASED PERSON'S PLACE OF INTERMENT

39. DECEASED PERSON'S DATE OF INTERMENT

40. DECEASED PERSON'S PLACE OF INTERMENT

41. DECEASED PERSON'S DATE OF INTERMENT

42. DECEASED PERSON'S PLACE OF INTERMENT

43. DECEASED PERSON'S DATE OF INTERMENT

44. DECEASED PERSON'S PLACE OF INTERMENT

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51. DECEASED PERSON'S DATE OF INTERMENT

52. DECEASED PERSON'S PLACE OF INTERMENT

53. DECEASED PERSON'S DATE OF INTERMENT

54. DECEASED PERSON'S PLACE OF INTERMENT

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59. DECEASED PERSON'S DATE OF INTERMENT

60. DECEASED PERSON'S PLACE OF INTERMENT

61. DECEASED PERSON'S DATE OF INTERMENT

62. DECEASED PERSON'S PLACE OF INTERMENT

63. DECEASED PERSON'S DATE OF INTERMENT

64. DECEASED PERSON'S PLACE OF INTERMENT

65. DECEASED PERSON'S DATE OF INTERMENT

66. DECEASED PERSON'S PLACE OF INTERMENT

67. DECEASED PERSON'S DATE OF INTERMENT

68. DECEASED PERSON'S PLACE OF INTERMENT

69. DECEASED PERSON'S DATE OF INTERMENT

70. DECEASED PERSON'S PLACE OF INTERMENT

71. DECEASED PERSON'S DATE OF INTERMENT

72. DECEASED PERSON'S PLACE OF INTERMENT

73. DECEASED PERSON'S DATE OF INTERMENT

74. DECEASED PERSON'S PLACE OF INTERMENT

75. DECEASED PERSON'S DATE OF INTERMENT

76. DECEASED PERSON'S PLACE OF INTERMENT

77. DECEASED PERSON'S DATE OF INTERMENT

BUREAU V. 8

FEB 27 1956

RECEIVED

1

INSTRUCTIONS

1 executed within **24 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2252

CERTIFICATE OF DEATH

02205

305

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>BOONSBORO</u>		<u>LIFE</u>		TOWN <u>BOONSBORO</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>POTOMAC ST. EXT.</u>				STREET ADDRESS (If rural give location) <u>POTOMAC ST. EXT.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>HERBERT GEORGE DAGENHART</u>				<u>FEBRUARY - 17, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>AUGUST - 4 - 1873</u>	<u>82-613</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>FARM</u>		<u>BOONSBORO WASH. CO. MD</u>		<u>U.S.A</u>	
13. FATHER'S NAME <u>AARON DAGENHART</u>				14. MOTHER'S MAIDEN NAME <u>SARAH DUTROVY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>MRS. MARTHA DAGENHART BOONSBORO MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
179X IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of penis</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 10, 1955</u> to <u>Feb 17, 1956</u> , that I last saw the deceased alive on <u>Feb 17, 1956</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>Boonsboro</u>				DATE SIGNED <u>2/19/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB. 21 - 1956</u>		<u>BOONSBORO CEMETERY</u>		<u>BOONSBORO WASH. CO. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>[Signature]</u>		<u>[Signature]</u>		<u>WM. F. BAST AND SONS</u>		<u>BOONSBORO MD.</u>	
DATE <u>Feb. 20, 1956</u>							

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02206

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 month 15 d.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>03</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>72 Washington County Jail</u>				d. STREET ADDRESS <u>418 Fremont St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>JOHN</u> Last <u>DELOSIER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 28, 1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood Pin Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Delosier</u>				14. MOTHER'S MAIDEN NAME <u>Lena Hartle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>1925-28</u>		16. SOCIAL SECURITY NO. <u>213-18-9457</u>		17. INFORMANT Address <u>Mrs. Lena Delosier Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>322.1 Acute Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Alcoholism</u> (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. - p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-28-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Fager</u>				24a. REC'D BY REGISTRAR <u>Feb 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB -29 - 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2208

02207

Dr. Ditto, III

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>3 days</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>734 Washington Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>AGNES</u>		(Middle) <u>MAY</u>		(Last) <u>DENMITT</u>		<u>Feb. 13, 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>May 13, 1882</u>	<u>73</u>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Union Bridge, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>George Stephens</u>				14. MOTHER'S MAIDEN NAME <u>- - - Stern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mr. Charles L. Denmitt</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Saddle Embolus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive vascular disease</u>				<u>15 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Broncho pneumonia</u>				<u>2 days</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 16, 1953</u> , to <u>Feb. 13, 1956</u> , that I last saw the deceased alive on <u>Feb. 13, 1956</u> , and that death occurred at <u>9:45</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Edward W. Ditto III</u>				ADDRESS (Street, city, town, state) <u>M.D. 212 W. Washington St. Hagerstown, Md.</u>		DATE SIGNED <u>2/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-16-56</u>		<u>Rest Haven Cemetery</u>		<u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 15, 1956</u>		<u>Edward W. Ditto III</u>		<u>Andrew K. Coffman</u>		<u>Hagerstown, Md</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED
MARTIN, JOHN
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH

DATE OF DEATH
PLACE OF DEATH
HOURS OF DEATH
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF BURIAL
PLACE OF BURIAL
HOURS OF BURIAL
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF INTERMENT
PLACE OF INTERMENT
HOURS OF INTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF CREMATION
PLACE OF CREMATION
HOURS OF CREMATION
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF REINTERMENT
PLACE OF REINTERMENT
HOURS OF REINTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

NAME OF DECEASED
MARTIN, JOHN
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH

DATE OF DEATH
PLACE OF DEATH
HOURS OF DEATH
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF BURIAL
PLACE OF BURIAL
HOURS OF BURIAL
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF INTERMENT
PLACE OF INTERMENT
HOURS OF INTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF CREMATION
PLACE OF CREMATION
HOURS OF CREMATION
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF REINTERMENT
PLACE OF REINTERMENT
HOURS OF REINTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

NAME OF DECEASED
MARTIN, JOHN
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH

DATE OF DEATH
PLACE OF DEATH
HOURS OF DEATH
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF BURIAL
PLACE OF BURIAL
HOURS OF BURIAL
SEX
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EDUCATION
MARRIAGE

DATE OF INTERMENT
PLACE OF INTERMENT
HOURS OF INTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF CREMATION
PLACE OF CREMATION
HOURS OF CREMATION
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF REINTERMENT
PLACE OF REINTERMENT
HOURS OF REINTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

NAME OF DECEASED
MARTIN, JOHN
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH

DATE OF DEATH
PLACE OF DEATH
HOURS OF DEATH
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF BURIAL
PLACE OF BURIAL
HOURS OF BURIAL
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF INTERMENT
PLACE OF INTERMENT
HOURS OF INTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF CREMATION
PLACE OF CREMATION
HOURS OF CREMATION
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

DATE OF REINTERMENT
PLACE OF REINTERMENT
HOURS OF REINTERMENT
SEX
RACE
RELIGION
EDUCATION
MARRIAGE

RECEIVED

BUREAU V. S.

FEB 17 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02208

2253

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clear Spring</u> OR TOWN <u>Rural Clear Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Boyd Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clear Spring, Md.</u> OR TOWN <u>Rural Clear Spring, Md.</u> STREET ADDRESS (If rural give location) <u>Boyd Road</u>	
3. NAME OF DECEASED: (Type or Print) <u>Etta May Dickey</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>18-56</u> <u>19</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Aug. 21, 1882</u>
9. AGE last birthday <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Home Duties</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Big Pool, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>Samuel Reed</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Dickerhoof</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Fannie Harnish Clear Spring, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
260X IMMEDIATE CAUSE		(A) <u>Acute Cardiac Failure</u> <u>20 min.</u>	
ANTECEDENT CAUSE (B)		(B) <u>Diabetes Mellitus</u> <u>8 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arterial Sclerosis</u>		<u>10 yrs.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 19, 1955</u> , to <u>Feb. 18, 1956</u> , that I last saw the deceased alive on <u>Feb. 18, 1956</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above. <u>2/20/56</u>			
SIGNATURE <u>David H. Brewer</u>		M. D. <u>David H. Brewer</u> ADDRESS <u>Clear Spring Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 21 56</u>	
NAME OF CEMETERY OR CREMATORY <u>Park Head Cemetery</u>		LOCATION (City, town, or county) (State) <u>Park Head, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 21 - 1956</u>		REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	
24. FUNERAL DIRECTOR <u>Adrian H. Rantaul</u>		ADDRESS <u>Clear Spring Md</u>	

RECEIVED

FEB 24 1956

BUREAU V. S.

2254

CERTIFICATE OF DEATH

Reg. Dist. No. 803

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Washington	MARYLAND	STATE Md.	COUNTY Washington
CITY (If outside corporate limits, write RURAL OR and give nearest town) Clear Spring Rl	LENGTH OF STAY (in this place) life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clear Spring Rl	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) 1	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Myrtle	(Middle) Mae	(Last) Ernst	2 2 19 56
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: May 3, 1883
9. AGE last birthday 72 yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10B. KIND OF BUSINESS OR INDUSTRY: home	11. BIRTHPLACE (State or foreign country): Near Clear Spring, Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.		13. FATHER'S NAME: Wilson Widmyer	
14. MOTHER'S MAIDEN NAME: Rebecca Fogle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: Fred Ernst Clear Spring, Md. R.F.D.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Thrombosis			Sudden
ANTECEDENT CAUSE (S) (B) Coronary Disease			8 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arterial Sclerosis & Hypertension			
19A. DATE OF OPERATION: 0	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 26, 1956 , to Feb 2, 1956 , that I last saw the deceased alive on Jan 31, 1956 , and that death occurred at 8:30 M, from the causes and on the date stated above.			
SIGNATURE David J. Brewer		M. D. Clear Spring Md. DATE SIGNED 2/2/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 2-4-56	NAME OF CEMETERY OR CREMATORY St. Pauls	LOCATION (City, town, or county) (State) Hagerstown rural Md.
DATE REC'D BY LOCAL REGISTRAR 2-3-56	REGISTRAR'S SIGNATURE Joseph W. Murray	24. FUNERAL DIRECTOR ADDRESS Adrian H. Rowland Clear Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 7 1956

RECEIVED

2255

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Sharpsburg		46 yrs.		OR TOWN Sharpsburg X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 207 W. Main Street				STREET ADDRESS (If rural give location) 207 W. Main Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
James Bernard Fisher				Feb. 12 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	Aug. 31 1909	46 yrs.	5 Months	11 Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or retirement)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Sheet Metal Worker		Fairchilds Co.		Sharpsburg		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Hood O. Fisher				Cora Gross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
No (If Yes, give year or dates of service) No		220-16-1441		207 W. Main St. Mrs. James Fisher Sharpsburg Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of the Lung						6 mos.?	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2/3/56		Biopsy of nodule in back - Squamous Cell Ca.					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 25, 1956 , to Feb. 12, 1956 that I last saw the deceased alive on Feb. 12, 1956 , and that death occurred at D.O.A. M, from the causes and on the date stated above.							
SIGNATURE Walter H. Shealy		M. D. Sharpsburg, Md.		DATE SIGNED 2/14/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 15 1956		Mt. View Cemetery		Sharpsburg Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb. 15, 1956		E. J. Boyer		Albert L. Leaf		Williamsport Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1956

BUREAU V. S.

2209

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Greencastle Pike			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DONALD Middle JAMES Last FRENCH				4. DATE OF DEATH Month Feb. Day 22 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6 1937	
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months 11 Days 15		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker				10b. KIND OF BUSINESS OR INDUSTRY Home Builders		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Donald James French Sr.				14. MOTHER'S MAIDEN NAME Vivian Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-34-3545			
17. INFORMANT Mr. Donald J. French				Address RFD #2 Williamsport Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute hydropneumothorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9/21 , 19 55 to 2/22 , 19 56 that I last saw the deceased alive on 2/22 , 19 56 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. F. Young				DATE SIGNED 2/23/56			
PHYSICIAN'S NAME (Type) Albert L. Leaf				ADDRESS 7 Church Street Williamsport Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 26-56		22c. NAME OF CEMETERY OR CREMATORY Salem Cemetery	
22d. LOCATION (City, town, or county) Near Hagerstown Maryland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf				24a. REC'D BY REGISTRAR Feb 25, 1956		24b. REGISTRAR'S SIGNATURE Chas H. Powers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
John Doe		35		Male		White		1920		1955		Home		Heart Disease		Coronary Artery Disease		Farmer		J. Doe, M.D.		J. Doe, M.D.	
Name of Informant		Relationship		Address		City		State		Zip		Date of Report		Signature of Informant		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Jane Doe		Wife		123 Main St.		Baltimore		MD		21201		1/15/56		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe	
Name of Informant		Relationship		Address		City		State		Zip		Date of Report		Signature of Informant		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
John Doe		Son		456 Oak St.		Baltimore		MD		21201		1/15/56		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe	

BUREAU V. S.

FEB 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 115C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02212

2256

CERTIFICATE OF DEATH

Dr. LeVan

Item 2, FilmG192 2-14-56 et

Reg. Dist. No. 305

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
TOWN <u>Boonsboro RFD</u>		<u>8 mos.</u>		STREET ADDRESS		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fahrney-Keedy Nursing Home</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>119 E. Washington St.</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>MARGARET</u>		(Middle) <u>VIOLA</u>		(Last) <u>GABE</u>		(Month) (Day) (Year)	
(Type or Print)						<u>Feb. 2 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>June 13, 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Fairplay, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Jacobs</u>				<u>Hester A. Tritch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Virginia Shank-Hag. R#3</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>450.1</u> IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>with gangrene of left leg</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Lech 15</u>, 19<u>55</u>, to <u>Feb 2</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb 1</u>, 19<u>56</u>, and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>A. W. LeVan</u>				<u>Boonsboro</u>			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-4-56</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 4, 1956</u>		<u>John H. Baird</u>		<u>Andrew K. Coffman-Hagerstown, Md.</u>			

CERTIFICATE OF DEATH

SEALAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

FEB 8 1936

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02213

2210

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Penna</u>		COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>6 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp.</u>				STREET ADDRESS (If rural give location) <u>Mt. Vernon Terrace</u>			
3. NAME OF DECEASED (Type or Print) <u>Maria J. Galindo</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2/16/1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 6, 1955</u>	9. AGE last birthday yrs. <u>8</u> Months <u>10</u> Days <u>19</u> Hours <u>56</u> Min.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jaima Galindo</u>				14. MOTHER'S MAIDEN NAME <u>Gretchen Kesmodel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Prime Galindo</u> <u>Waynesboro, Pa.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
571.0 IMMEDIATE CAUSE (A) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Vomiting + Diarrhea</u>				<u>6 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/9/56</u> , to <u>2/15/56</u> , that I last saw the deceased alive on <u>2/15/56</u> , and that death occurred at <u>2:15A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>A. M. Becerra</u>				ADDRESS (Street, city, town, state) <u>302 N. Potomac</u>		DATE SIGNED <u>2/16/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 16, 1956</u>		REGISTRAR'S SIGNATURE <u>Frank H. Gowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry T. Meers</u>		ADDRESS <u>Calvert Hall</u>	

2047222375

CERTIFICATE OF DEATH

Form 100-1

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Time of death (Hour, minute)

7. Cause of death (List all causes, beginning with immediate cause)

8. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

9. Signature of attending physician (Print name and sign)

10. Signature of medical examiner (Print name and sign)

11. Signature of coroner (Print name and sign)

12. Signature of registrar (Print name and sign)

13. Signature of funeral director (Print name and sign)

14. Signature of informant (Print name and sign)

15. Address of deceased (Street, City, State, Zip)

16. Address of informant (Street, City, State, Zip)

17. Address of funeral home (Street, City, State, Zip)

18. Address of medical examiner (Street, City, State, Zip)

19. Address of coroner (Street, City, State, Zip)

20. Address of registrar (Street, City, State, Zip)

21. Address of informant (Street, City, State, Zip)

22. Address of funeral home (Street, City, State, Zip)

23. Address of medical examiner (Street, City, State, Zip)

24. Address of coroner (Street, City, State, Zip)

25. Address of registrar (Street, City, State, Zip)

26. Address of informant (Street, City, State, Zip)

27. Address of funeral home (Street, City, State, Zip)

28. Address of medical examiner (Street, City, State, Zip)

29. Address of coroner (Street, City, State, Zip)

30. Address of registrar (Street, City, State, Zip)

31. Signature of attending physician (Print name and sign)

32. Signature of medical examiner (Print name and sign)

33. Signature of coroner (Print name and sign)

34. Signature of registrar (Print name and sign)

35. Signature of funeral director (Print name and sign)

36. Signature of informant (Print name and sign)

37. Address of deceased (Street, City, State, Zip)

38. Address of informant (Street, City, State, Zip)

39. Address of funeral home (Street, City, State, Zip)

40. Address of medical examiner (Street, City, State, Zip)

41. Address of coroner (Street, City, State, Zip)

42. Address of registrar (Street, City, State, Zip)

43. Address of informant (Street, City, State, Zip)

44. Address of funeral home (Street, City, State, Zip)

45. Address of medical examiner (Street, City, State, Zip)

46. Address of coroner (Street, City, State, Zip)

47. Address of registrar (Street, City, State, Zip)

48. Address of informant (Street, City, State, Zip)

49. Address of funeral home (Street, City, State, Zip)

50. Address of medical examiner (Street, City, State, Zip)

51. Address of coroner (Street, City, State, Zip)

52. Address of registrar (Street, City, State, Zip)

53. Address of informant (Street, City, State, Zip)

54. Address of funeral home (Street, City, State, Zip)

55. Address of medical examiner (Street, City, State, Zip)

56. Address of coroner (Street, City, State, Zip)

57. Address of registrar (Street, City, State, Zip)

58. Address of informant (Street, City, State, Zip)

59. Address of funeral home (Street, City, State, Zip)

60. Signature of attending physician (Print name and sign)

61. Signature of medical examiner (Print name and sign)

62. Signature of coroner (Print name and sign)

63. Signature of registrar (Print name and sign)

64. Signature of funeral director (Print name and sign)

65. Signature of informant (Print name and sign)

66. Address of deceased (Street, City, State, Zip)

67. Address of informant (Street, City, State, Zip)

68. Address of funeral home (Street, City, State, Zip)

69. Address of medical examiner (Street, City, State, Zip)

70. Address of coroner (Street, City, State, Zip)

71. Address of registrar (Street, City, State, Zip)

72. Address of informant (Street, City, State, Zip)

73. Address of funeral home (Street, City, State, Zip)

74. Address of medical examiner (Street, City, State, Zip)

75. Address of coroner (Street, City, State, Zip)

76. Address of registrar (Street, City, State, Zip)

77. Address of informant (Street, City, State, Zip)

78. Address of funeral home (Street, City, State, Zip)

79. Address of medical examiner (Street, City, State, Zip)

80. Address of coroner (Street, City, State, Zip)

81. Address of registrar (Street, City, State, Zip)

82. Address of informant (Street, City, State, Zip)

83. Address of funeral home (Street, City, State, Zip)

84. Address of medical examiner (Street, City, State, Zip)

85. Address of coroner (Street, City, State, Zip)

86. Address of registrar (Street, City, State, Zip)

87. Address of informant (Street, City, State, Zip)

88. Address of funeral home (Street, City, State, Zip)

89. Signature of attending physician (Print name and sign)

90. Signature of medical examiner (Print name and sign)

91. Signature of coroner (Print name and sign)

92. Signature of registrar (Print name and sign)

93. Signature of funeral director (Print name and sign)

94. Signature of informant (Print name and sign)

95. Address of deceased (Street, City, State, Zip)

96. Address of informant (Street, City, State, Zip)

97. Address of funeral home (Street, City, State, Zip)

98. Address of medical examiner (Street, City, State, Zip)

99. Address of coroner (Street, City, State, Zip)

100. Address of registrar (Street, City, State, Zip)

101. Address of informant (Street, City, State, Zip)

102. Address of funeral home (Street, City, State, Zip)

103. Address of medical examiner (Street, City, State, Zip)

104. Address of coroner (Street, City, State, Zip)

105. Address of registrar (Street, City, State, Zip)

106. Address of informant (Street, City, State, Zip)

107. Address of funeral home (Street, City, State, Zip)

108. Address of medical examiner (Street, City, State, Zip)

109. Address of coroner (Street, City, State, Zip)

110. Address of registrar (Street, City, State, Zip)

111. Address of informant (Street, City, State, Zip)

112. Address of funeral home (Street, City, State, Zip)

113. Address of medical examiner (Street, City, State, Zip)

114. Address of coroner (Street, City, State, Zip)

115. Address of registrar (Street, City, State, Zip)

116. Address of informant (Street, City, State, Zip)

117. Address of funeral home (Street, City, State, Zip)

118. Signature of attending physician (Print name and sign)

119. Signature of medical examiner (Print name and sign)

120. Signature of coroner (Print name and sign)

121. Signature of registrar (Print name and sign)

122. Signature of funeral director (Print name and sign)

123. Signature of informant (Print name and sign)

124. Address of deceased (Street, City, State, Zip)

125. Address of informant (Street, City, State, Zip)

126. Address of funeral home (Street, City, State, Zip)

127. Address of medical examiner (Street, City, State, Zip)

128. Address of coroner (Street, City, State, Zip)

129. Address of registrar (Street, City, State, Zip)

130. Address of informant (Street, City, State, Zip)

131. Address of funeral home (Street, City, State, Zip)

132. Address of medical examiner (Street, City, State, Zip)

133. Address of coroner (Street, City, State, Zip)

134. Address of registrar (Street, City, State, Zip)

135. Address of informant (Street, City, State, Zip)

136. Address of funeral home (Street, City, State, Zip)

137. Address of medical examiner (Street, City, State, Zip)

138. Address of coroner (Street, City, State, Zip)

139. Address of registrar (Street, City, State, Zip)

140. Address of informant (Street, City, State, Zip)

141. Address of funeral home (Street, City, State, Zip)

142. Address of medical examiner (Street, City, State, Zip)

143. Address of coroner (Street, City, State, Zip)

144. Address of registrar (Street, City, State, Zip)

145. Address of informant (Street, City, State, Zip)

146. Address of funeral home (Street, City, State, Zip)

INSTRUCTIONS

1. This form is to be filled out by the attending physician, medical examiner, coroner, registrar, funeral director, or informant.

2. The cause of death should be stated in full, including the immediate cause, the underlying cause, and any contributing causes.

3. The manner of death should be stated as Natural, Accidental, Suicide, Homicide, or Undetermined.

4. The signature of the attending physician, medical examiner, coroner, registrar, funeral director, or informant must be present.

5. The address of the deceased, informant, funeral home, medical examiner, coroner, registrar, and informant must be present.

6. This form is to be filed with the local health department and a copy sent to the State Department of Health.

BUREAU

FEB 20

RECEIVED

2211

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81 Washington Co. Hospital</u>		STREET ADDRESS (If rural give location) <u>Washington Co. Hospital</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Baby By Carling</u>		DEATH: <u>2</u> / <u>8</u> / <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE / MARRIED / WIDOWED / DIVORCED (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>2/7/1956</u>
9. AGE last birthday <u>8</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Paul E. Carling</u>		14. MOTHER'S MAIDEN NAME: <u>Luille Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mr. Paul E. Carling, Hagerstown, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		8 hrs	
IMMEDIATE CAUSE (A) <u>Febrile shock</u>		8 hrs	
ANTECEDENT CAUSE (B) <u>Cholera</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/7/56</u> 19 <u>56</u> , to <u>2/8/56</u> 19 <u>56</u> , that I last saw the deceased alive on <u>2/8/56</u> , and that death occurred at <u>3:30 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Paul E. Carling</u>		ADDRESS <u>Hagerstown</u> DATE SIGNED <u>2/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/9/56</u> NAME OF CEMETERY OR CREMATORY <u>Montgomery Church Cemetery</u> LOCATION (City, town, or county) (State) <u>Franklin Co. Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/9/56</u>		REGISTRAR'S SIGNATURE <u>Charles H. Zimmerman</u> 24. FUNERAL DIRECTOR <u>Harold W. Zimmerman, Greenfield, Pa.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02215

Dr. Hirshman 2212 **CERTIFICATE OF DEATH**

Reg. Dist. No. 303

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>61 yrs.</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>26 East Lee St.</u>				STREET ADDRESS (If rural give location) <u>26 East Lee St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>MAX</u>		(Middle) <u>M.</u>		(Last) <u>GERBER</u>		<u>Feb. 24, 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec 5 1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Owner Hag. Iron & Junk Co</u>			<u>Latvia</u>		<u>USA</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Judel Hyman Gerber</u>				<u>Bessie C. Nachensohn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>No</u>			<u>214-09-2669</u>		<u>Mrs. Rose Gerber-26 E. Lee St.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediately</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				<u>2 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year)			21a. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?		
			White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> al work <input type="checkbox"/> al work <input type="checkbox"/>				
22. I hereby certify that I attended the deceased from <u>7/29, 1953</u>, to <u>2/24, 1956</u>, that I last saw the deceased alive on <u>Oct 11, 1955</u>, and that death occurred at <u>6 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Henry J. Wolman</u>				DATE SIGNED <u>2/24/56</u>			
				ADDRESS (Street, city, town, state) <u>Hagerstown Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-20-56</u>		<u>B'nai Abraham Cemetery nr. Hagerstown, Md.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb. 28, 1956</u>		<u>L. Hest H. Bowers</u>		<u>Andrew K. Coffman-Hagerstown, Md.</u>			

2018 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form 10-1-18

DEPARTMENT OF HEALTH - BALTIMORE 10

DEPARTMENT OF HEALTH - BALTIMORE 10

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DEPARTMENT OF HEALTH - BALTIMORE 10

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BUREAU V. 5

MAR 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2257

CERTIFICATE OF DEATH

Reg. Dist. No. 022166/1

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>WASHINGTON</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>WASHINGTON</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport</u>	LENGTH OF STAY (in this place) <u>30 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hagerstown Pike</u>		STREET ADDRESS (If rural give location) <u>Hagerstown Pike</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Paul Edward Gigeous</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 4 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 20 1895</u>
9. AGE last birthday <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life. <u>Retired</u>): <u>COLLECTOR</u>		10B. KIND OF BUSINESS <u>Potomac River Bridge</u>	
11. BIRTHPLACE (State or foreign country): <u>Breathesville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jasper N. Gigeous</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Florence Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World War 216-22-1699</u>	
17. INFORMANT & ADDRESS: <u>Hagerstown Pike Md.</u> <u>Mrs. Donnie A Gigeous Williamsport</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.0</u>		<u>5 hrs.</u>	
ANTECEDENT CAUSE (S)		<u>18 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Ventricular fibrillation</u>			
DUE TO			
(B) <u>Arteriosclerotic Heart Disease</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30</u> 19 <u>53</u> to <u>1/4</u> 19 <u>56</u> , that I last saw the deceased alive on <u>1/2</u> 19 <u>56</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.			
SIGNATURE <u>Donnie A. Gigeous</u>		ADDRESS <u>Williamsport Md.</u>	
DATE SIGNED <u>6 Feb 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 7-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 6 - 56</u>		REGISTRAR'S SIGNATURE <u>E. Lee M. Olney</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 8 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02217

2258

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Williamsport</u>	<u>1 month</u>	TOWN <u>Funkstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>90 Williamsport Sanitarium</u>		<u>29. E. Cemetery St.</u>	<u>@ 6 PM</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Charles</u>	(Middle) <u>Wilford</u>	(Last) <u>Green</u>	DATE OF DEATH: <u>Feb. 17 1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Sept. 8, 1873</u>
9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>CARPENTER</u>		<u>SELF EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Myersville, Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Hezekiah Green</u>		<u>Euna M. Betz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. (Initials)	
<u>NO</u>		<u>Arthur Green</u>	
17. MEDICAL CERTIFICATION		18. INFORMANT & ADDRESS:	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>8249 E. Irwin St. Hagerstown, Md.</u>	
IMMEDIATE CAUSE (A)		INTERVAL BETWEEN ONSET AND DEATH	
<u>Cerebral Vascular Accident</u>		<u>11 hours</u>	
ANTECEDENT CAUSE (S) DUE TO			
(B) <u>Hypertensive Cerebrovascular Heart Disease</u>		<u>4 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Diabetes mellitus</u>		<u>5 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 31, 1956</u> to <u>Feb. 17, 1956</u> that I last saw the deceased alive on <u>Feb. 17, 1956</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul H. M.D.</u>		ADDRESS <u>Williamsport, Md.</u>	
DATE SIGNED <u>17 Feb 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>BURIAL</u>		<u>FEB. 19, 1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>FUNKSTOWN CEMETERY</u>		<u>FUNKSTOWN WASH. CO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Feb. 18, 1956</u>		<u>E. Lee M. Elroy</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Wm. F. BAST AND SONS</u>		<u>BOONSBORO MD.</u>	

BUREAU V. S.

FEB 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02218

Dr. Kohler

2259

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Smithsburg R#2</u>		<u>7 yrs.</u>		TOWN <u>Smithsburg R#2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ringgold Road</u>				STREET ADDRESS (If rural give location) <u>Ringgold Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u> (Middle) <u>STEINER</u> (Last) <u>GREEN, JR.</u>				(Month) <u>Feb.</u> (Day) <u>29.</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 26, 1896</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Columbia Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Green, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Birney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-7640</u>		17. INFORMANT & ADDRESS <u>Mr. Kenneth W. Green</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary insufficiency</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertensive Cardiac disease</u>						<u>4 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 19 56</u> to <u>Feb 29 56</u> , that I last saw the deceased alive on <u>Feb 29 19 56</u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>E. G. Kohler</u>				ADDRESS (Street, city, town, state) <u>San Antonio</u>			
DATE SIGNED <u>3/1/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	
24. REC'D BY REGISTRAR <u>Mar. 5. 1956</u>		REGISTRAR'S SIGNATURE <u>Leo. H. Ferguson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	

CERTIFICATE OF DEATH

2549

Age, Sex, Race

Place of Birth, Date of Birth

Married

Single

Widow

Divorced

Never married

Other

Unknown

Refused

Other

Unknown

Refused

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2260

CERTIFICATE OF DEATH

02219

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SECURITY</u>		<u>43 yrs.</u>		TOWN <u>SECURITY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Martha</u> (Middle) <u>Anni</u> (Last) <u>Grimm</u>				(Month) <u>2</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Nov 15, 1895</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Domestic</u>		<u>Washington Co., Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Will Holmes</u>				<u>Eileen L. Jamison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Chas. W. Grimm Security Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Arterio sclerotic heart disease with myocardial failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Psychosis (Semile Manic Type)</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 22</u>, 19<u>56</u>, to <u>Feb 22</u>, 19<u>56</u>, that I last saw the deceased alive on <u>22 Feb</u>, 19<u>56</u>, and that death occurred at <u>10:30 P</u>.M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>W. H. Lusby</u>				<u>230 N Potomac Harpers</u>		<u>23 Feb 56</u>	
M. D. <u>W. H. Lusby</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/25/56</u>		<u>Rest Haven Cemetery</u>		<u>Harpers station Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb 24 1956</u>		<u>W. H. Lusby</u>		<u>Rest Haven Funeral Chapel Inc.</u>		<u>Wm. A. Horst & Pross</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED William H. Harrison		2. SEX Male		3. AGE 45 yrs		4. RACE White		5. BIRTH DATE 1872		6. BIRTH PLACE Washington, D. C.		7. DEATH DATE Feb 27, 1956		8. DEATH PLACE Baltimore, Md.	
9. OCCUPATION Teacher		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. Harrison		13. SIGNATURE OF WITNESSES J. H. Harrison, J. H. Harrison		14. SIGNATURE OF DECEASED J. H. Harrison		15. SIGNATURE OF FUNERAL HOME J. H. Harrison		16. SIGNATURE OF REGISTRAR J. H. Harrison	

BUREAU V. S.

FEB 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02220

2213

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 hour			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown				d. STREET ADDRESS RFD #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Corinne Middle Grace Last Grove				4. DATE OF DEATH Month Feb. Day 19 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1905		9. AGE (In years last birthday) yrs. 50	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harvey Paden				14. MOTHER'S MAIDEN NAME Ida Trovinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - -		17. INFORMANT James S. Grove, Hagerstown, RFD 1, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension (c) Obesity - Diabetes						INTERVAL BETWEEN ONSET AND DEATH 12 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1956 , to Feb 19, 1956 , that I last saw the deceased alive on Feb 19, 1956 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 2/24/56							
ACTUAL SIGNATURE Edgar S. Hood M.D.		PHYSICIAN'S NAME (Type) Edgar S. Hood					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-22-56		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md. ADDRESS				24a. REC'D BY REGISTRAR Feb 23, 1956		24b. REGISTRAR'S SIGNATURE Blair H. Powers	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2261

Item 13 Film G192 2-10-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02221

307

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>BROWNSVILLE</u>		<u>LIFE</u>		TOWN <u>BROWNSVILLE</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>MAIN ST.</u>				<u>MAIN ST.</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)		OF DEATH: <u>FEBRUARY-2-1956</u>	
<u>EDNA</u>		<u>M</u>		<u>HARDING</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>FEMALE</u>		<u>WHITE</u>		<u>MARRIED</u>		<u>DECEMBER-18-1893</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday		IF UNDER 1 YEAR	
<u>HOUSE WIFE</u>		<u>OWN HOME</u>		<u>62-1-14</u> yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>BROWNSVILLE WASH. CO. MD.</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>ADA L. FOUCHE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>NO</u>				<u>NONE</u>			
17. INFORMANT & ADDRESS:							
<u>HARVEY E. HARDING BROWNSVILLE MD.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma - uterine</u>						<u>18 mos?</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				<u>Carcinoma - uterine</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11</u> , 19 <u>54</u> , to <u>2-2-56</u> , that I last saw the deceased alive on <u>2-2-56</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>2-3-56</u>			
M. D. <u>Brownsville Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB. 5, 1956</u>		<u>CHURCH OF THE BRETHREN CEMETERY</u>		<u>BROWNSVILLE MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 4/56</u>		<u>Mrs. Katherine J. Jagers</u>		<u>W. F. BAST AND SONS</u>		<u>BOONSBORO MD.</u>	

BUREAU V. S.

FEB 8 1956

RECEIVED

2262 CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Washington</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Wash.</i>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <i>Garnetts Mills</i>		LENGTH OF STAY (in this place) <i>Life</i>		TOWN <i>Garnetts Mills</i>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>Cicely Ann Harris</i>				<i>2 14 19 56</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>Col.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <i>11-30-1868</i>	
9. AGE last birthday: <i>87</i> yrs.		10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME: <i>Robert A. Anderson</i>		14. MOTHER'S MAIDEN NAME: <i>unknown</i>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>—</i>		17. INFORMANT & ADDRESS: <i>Mr. Camrill Robbins, Knoxville Md</i>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<i>2 yrs</i>	
Immediate cause (a) <i>Carcinoma of left Breast</i>					
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO					
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?	
22. I hereby certify that I attended the deceased from <i>Aug 10, 1955</i> to <i>Feb. 14, 1956</i> , that I last saw the deceased alive on <i>Feb 14, 1956</i> , and that death occurred at <i>9:15 pm</i> from the causes and on the date stated above.					
SIGNATURE <i>W. L. W. M. D.</i>		(Degree or title)		DATE SIGNED <i>2/15/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>2-14-56</i>		<i>Mt. Maria</i>	
LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<i>Garnetts Mills Md</i>		<i>Feb. 18-1956</i>		<i>W. L. W. M. D.</i>	
24. FUNERAL DIRECTOR		ADDRESS			
<i>C. A. Felt & Co</i>		<i>Brunswick Md</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 20 1956

RECEIVED

2214

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
03 <u>HAGERSTOWN</u>		<u>2 WEEKS</u>		<u>BOONSBORO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
81 <u>WASH. CO. HOSPITAL</u>				<u>N. MAIN ST. EXTENDED</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>HARRY S. HARTMAN</u>				<u>FEBRUARY-9-1956</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>MALE</u>		<u>WHITE</u>		<u>MARRIED</u>		<u>1883</u>	
						9. AGE last birthday	
						<u>72-6-15 yrs.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>RETIRED MERCHANT OWN STORE</u>				<u>OWN STORE</u>		<u>TIFFIN OHIO</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>ANDREW HARTMAN</u>				<u>CATHERINE SPECK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>220-18-3283</u>		<u>MRS. FAYE HARTMAN BOONSBORO MD.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE				(A) <u>Acute coronary occlusion (sudden death)</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Arteriosclerotic heart disease (previous coronary occlusion)</u>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/25, 1956</u> , to <u>2/9, 1956</u> , that I last saw the deceased alive on <u>2/8, 1956</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. H. H. Bowers</u>				ADDRESS <u>154 W. Washington St.</u>		DATE SIGNED <u>2/10/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>				<u>FEB. 11-1956</u>		<u>BOONSBORO MAUSOLEUM BOONSBORO WASH. CO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/26.11.1956</u>				REGISTRAR'S SIGNATURE <u>Dr. H. H. Bowers</u>		24. FUNERAL DIRECTOR ADDRESS <u>W. M. F. BAST AND SONS BOONSBORO MD</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P. R. WADE

P. R. Houlahan
154 W. WASH. ST.

RECEIVED

FEB 14 1956

BUREAU V. S.

2263

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Big Pool</u>	LENGTH OF STAY (in this place) <u>6 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Big Pool, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>	STREET ADDRESS (If rural, give location) <u>Indian Spring Road</u>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Achsia E.</u>	(Middle) <u>Hill</u>	(Last)	(Month) <u>Feb</u> (Day) <u>18</u> (Year) <u>1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Oct. 20, 1885</u>
9. AGE last birthday: <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Home Duties</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Fulton Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>Moses True</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Ophman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. June McAllister - Big Pool, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Adenocarcinoma of Colon</u>			<u>2 yrs.</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>4/10/54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Adenocarcinoma of Colon</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/27</u> , 19 <u>54</u> to <u>2/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>56</u> , and that death occurred at <u>1:00</u> P, from the causes and on the date stated above.			
SIGNATURE <u>Joseph W. Murray</u>		DATE SIGNED <u>20 Feb 56</u>	
M. D. <u>William H. T. Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 22-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Clear Spring, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 21-1956</u>		REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	
24. FUNERAL DIRECTOR <u>William H. T. Md.</u>		ADDRESS <u>Clear Spring Md</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2264

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02225

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS R # 2			
3. NAME OF DECEASED (Type or print) First John Middle Hubert Last Hines				4. DATE OF DEATH Month Feb. Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1896		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 9 Days 25	IF UNDER 24 HRS. Hours 25 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Wm Bester Florist		11. BIRTHPLACE (State or foreign country) Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Hines				14. MOTHER'S MAIDEN NAME Emma K. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. # 1 217-03-5432		17. INFORMANT Mrs. Annie K. Hines - R # 2 Boonsboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 10 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-56		22c. NAME OF CEMETERY OR CREMATORY Boonsboro		22d. LOCATION (City, town, or county) (State) Boonsboro Wash. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bart Funnell Home By John H. Bart				24a. REC'D BY REGISTRAR John H. Bart		24b. REGISTRAR'S SIGNATURE John H. Bart	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 2 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18)2226

2215 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Penna.		COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR 03 Hagerstown		LENGTH OF STAY (in this place) 2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR 75X-3 Waynesboro			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 96 Martin Manor Rest Home				STREET ADDRESS (If rural give location) 110 S. Broad St.			
3. NAME OF DECEASED: (First) (Middle) (Last) Emma Cora Hoover				4. DATE (Month) (Day) (Year) OF DEATH: Feb. 8, 1956			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: Oct. 27, 1861	9. AGE last birthday 94 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: David Hoover				14. MOTHER'S MAIDEN NAME: Elizabeth Stephey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: Raymond Spahr, Smithsburg, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 334X (A) Terminal Bronchopneumonia						36 hrs	
ANTECEDENT CAUSE (S) (B) General Anterior Sclerosis						7 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Generalized Anterior Sclerosis						15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 1, 1956 to Feb 8, 1956 that I last saw the deceased alive on Feb 8, 1956 , and that death occurred at 5: A M, from the causes and on the date stated above. SIGNATURE Y. G. Kohler ADDRESS Smithsburg Md DATE SIGNED 2/8/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 2-11-56		NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		LOCATION (City, town, or county) (State) Smithsburg, Md.	
DATE REC'D BY LOCAL REGISTRAR Feb. 10, 1956		REGISTRAR'S SIGNATURE Phas H. Bowers		24. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son, Smithsburg			

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FEB 14 1950

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02227

2216

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 136 Winter St.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Horning		4. DATE OF DEATH Month Day Year Feb 28 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1883
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Fairplay Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albertus Stover		14. MOTHER'S MAIDEN NAME Martha Danner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Address Mrs. Martha Negley Hag. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Heart Disease DUE TO (c) Hypertensive Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH Immediate 2 yrs. 9 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 19 56 to Feb 28, 19 56 , that I last saw the deceased alive on Feb 28, 19 56 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Minnich M.D.		ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 2/29/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF 3-2-56	
22c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		22d. LOCATION (City, town, or county) (State) Near Tilghmanton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hag. Md.		24a. REC'D BY REGISTRAR Mar 5, 1956 24b. REGISTRAR'S SIGNATURE Blair H. Bowers	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Counter signed
Feb. 21-56
D.M.E. Work Co. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02228

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>626 Salem Avenue</u>		STREET ADDRESS (If rural give location) <u>626 Salem Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Paul</u> <u>Orator</u> <u>Horton</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>20</u> <u>19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 12, 1892</u>
9. AGE last birthday <u>63</u> yrs. <u>11</u> Months <u>8</u> Days <u></u> Hours <u></u> Min.		10. BIRTHPLACE (State or foreign country): <u>Dudley, Pa.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Miner</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Isaac Newton Horton</u>		14. MOTHER'S MAIDEN NAME: <u>Emily Sweet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>193-09-6088</u>	
17. INFORMANT & ADDRESS: <u>Miss Elva Horton, Hagerstown, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>			<u>3 days</u>
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerosis Generalized</u>			<u>Indef.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		<u>street, office bldg., etc.</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>never</u> , 19....., to 19....., that I last saw the deceased alive on <u>never</u> , 19....., and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Paul J. Keadle</u>		ADDRESS <u>Hagerstown</u> DATE SIGNED <u>2-21-56</u>	
M. D. <u></u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-23-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Brod-Top Cemetery</u>		LOCATION (City, town, or county) (State) <u>Brod-Top, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 20, 1956</u>		REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Suter-Rouzer Fun. Home, Hagerstown, Md.</u>	

RECEIVED

FEB 24 1956

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02229

2265 CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>256 W. Main St Hancock</u>		<u>4 5 Yrs</u>		TOWN <u>256 W. Main St Hancock Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural give location) <u>256 W. Main St Hancock Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Martin</u> (Middle) <u>Van Buren</u> (Last) <u>Keefer</u>				(Month) <u>2</u> (Day) <u>5</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>M</u>	<u>W</u>	<u>Married</u>	<u>April 1 1884</u>	<u>71</u> yrs.	Months <u>10</u>	Days <u>4</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if (Specify))		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Truck Forman</u>		<u>B&O Railroad</u>		<u>Fulton County Penna.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>David Keefer</u>				<u>Phoebe Weeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>705-05-9177</u>		<u>Mrs Sally Keefer 256 W. Main St Hancock</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Death</u> to <u>arrival</u>, that I last saw the deceased alive on <u>2-5</u>, 19<u>56</u>, and that death occurred at <u>4:45 PM</u>, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Herbert R. Tobias</u> M.D.				<u>Berkeley Springs W. Va</u> <u>2-8-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>2-8-56</u>		<u>Presbyterian Cemetery</u>		<u>Hancock Washington Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>3/8/56</u>		<u>[Signature]</u>		<u>[Signature]</u>			
DATE				ADDRESS			
				<u>Hancock Md</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

RECEIVED
 FEB 15 1956
 BUREAU V. 3

1956-1-15

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02230

2218 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>9 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Waynesboro</u>		<u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>Waynesboro Pa., #1</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Richard</u> (Middle) <u>David</u> (Last) <u>Kendall</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 3, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 26, 1922</u>	9. AGE last birthday <u>33</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Magnus Metal Works</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Smithsburg Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur E. Kendall</u>				14. MOTHER'S MAIDEN NAME <u>Maude Webb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-16-1445</u>		17. INFORMANT & ADDRESS <u>Mrs. Betty B. Kendall, Waynesboro Pa. #1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>590x</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Acute glomerulo nephritis & uremia About 2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Upper respiratory infection & "Sore throat"</u> ? 3 wks.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-26</u> , 19 <u>56</u> , to <u>2-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-3</u> , 19 <u>56</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John H. Bowers, M.D.</u>				ADDRESS (Street, city, town, state) <u>154 W. Washington St. Hagerstown, Md.</u>			
DATE <u>Feb. 7/1956</u>				DATE SIGNED <u>2/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/6/56</u>		NAME OF CEMETERY OR CREMATORY <u>Quincy</u>		LOCATION (City, town, or county) (State) <u>Quincy, Franklin Pa.</u>	
24. REC'D BY REGISTRAR <u>Feb. 7/1956</u>		REGISTRAR'S SIGNATURE <u>John H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Gove, Waynesboro Pa.</u>		ADDRESS	

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

OCCUPATION

CAUSE OF DEATH

PERIOD OF ILLNESS

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF FUNERAL HOME

NAME OF UNDERTAKER

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF CLERK

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BUREAU V. S.

FEB 9 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2266

CERTIFICATE OF DEATH

02231

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Maugansville		c. LENGTH OF STAY IN 1b 22 mon.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 Mennonite Home		d. STREET ADDRESS X	
3. NAME OF DECEASED (Type or print) Emma First Katie Middle Kershner Last		4. DATE OF DEATH Feb Month 26 Day 19 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1866
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cearfoss Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Cunningham		14. MOTHER'S MAIDEN NAME Annie Cosey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT J. Clyde Cunningham		Address Cearfoss Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension - Arterio sclerotic Cardiovascular DUE TO disease with myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 10 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) M
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb , 19 46 , to 19 Feb , 19 56 , that I last saw the deceased alive on Feb , 19 56 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		ADDRESS (Street, city or town, state) 230 N. Potomac St	
PHYSICIAN'S NAME (Type) F. F. Lusby		DATE SIGNED 28 Feb 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-29-56	22c. NAME OF CEMETERY OR CREMATORY Salem Reformed
22d. LOCATION (City, town, or county) (State) Near Cearfoss Md.		24a. REC'D BY REGISTRAR Mar. 5, 1956	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24b. REGISTRAR'S SIGNATURE Hag. Md.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1956

RECEIVED

State of Maryland

1956

1956

George W. Washington

1956

1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02232

Dr. Bell

2219 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>5 days</u>		OR TOWN <u>Hagerstown</u>		OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>24 East Antietam St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>VIRGINIA BELLE KIDWELL</u>				<u>Feb. 16, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>May 23, 1884</u>	<u>91</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Slanesville, W. Va.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jonathan Kidwell</u>				<u>Martha Kidwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mr. Guy S. Kidwell</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>903.0</u> IMMEDIATE CAUSE (A) <u>Bronchopneumonia (terminal)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Fraetured right hip.</u>						<u>6 days.</u>	
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized arteriosclerosis</u>						<u>Years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>None</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>Home</u>		<u>Hagerstown, Washington, Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>February 10, 1956</u>		<u>M.</u>		<u>Fell over chair at her home.</u>			
22. I hereby certify that I attended the deceased from <u>Feb. 11, 1956</u>, to <u>Feb. 16, 1956</u>, that I last saw the deceased alive on <u>Feb. 16, 1956</u>, and that death occurred at <u>5:25P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Ra Bee</u>		<u>Hagerstown, Maryland.</u>		<u>Feb. 17, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-19-56</u>		<u>Mt. Union Cemetery</u>		<u>Hampshire Co. Slanesville, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Feb. 20, 1956</u>		<u>Andrew K. Coffman</u>		<u>Andrew K. Coffman-Hagerstown, Md.</u>			

CERTIFICATE OF DEATH

Reg. Division

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Time of Death

8. Cause of Death

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Health Officer

15. Signature of Burial Officer

16. Signature of Undertaker

17. Signature of Funeral Home

18. Signature of Cemetery

19. Signature of Burial

20. Signature of Interment

21. Signature of Burial

22. Signature of Interment

23. Signature of Burial

24. Signature of Interment

25. Signature of Burial

26. Signature of Interment

27. Signature of Burial

28. Signature of Interment

29. Signature of Burial

30. Signature of Interment

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58. Signature of Interment

59. Signature of Burial

60. Signature of Interment

BUREAU V. S.

FEB 23 1956

RECEIVED

2220

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
TOWN <u>HAGERSTOWN</u>		TOWN <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>535 Guilford Ave</u>		STREET ADDRESS (If rural, give location) <u>535 Guilford Ave</u>	
3. NAME OF DECEASED (First) <u>Calvin</u> (Middle) <u>Daniel</u> (Last) <u>Kimble</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>10</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Nov. 10, 1913</u>
9. AGE last birthday <u>42</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Elmer W. Kimble</u>		14. MOTHER'S MAIDEN NAME <u>INA G. Zeigler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>217-18-7191</u>	
17. INFORMANT AND ADDRESS <u>INA Zeigler</u>		<u>535 Guilford Ave</u> <u>HAGERSTOWN, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
581.0 Immediate cause (a) <u>Gastric Hemorrhage</u>		2 hrs
Antecedent cause(s) (b) <u>Chronic Liver</u>		2 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OR office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE In SW Smith (Degree or title) md ADDRESS Hagerstown, Md DATE SIGNED 2/11/56

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/12/56</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cem</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 11, 1956</u>	REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel Inc</u> ADDRESS <u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2221

CERTIFICATE OF DEATH

02234

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemont</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1100 Bl., Jefferson St.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Kindle</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> , Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/2/1864</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Keedysville Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Israel Churchey</u>		14. MOTHER'S MAIDEN NAME <u>Jane Metz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. John Wertz, Harrisburg Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1</u> , 19 <u>55</u> , to <u>2/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Hess</u>				ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u>		DATE SIGNED <u>2/25/56</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ref. Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cavetown, Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hone</u>				ADDRESS <u>Hagerstown Pa.</u>		24a. REC'D BY REGISTRAR <u>Feb. 27. 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Walter H. Powers</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SERVICE		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

2222

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		STATE <u>MARYLAND</u>		COUNTY <u>WASHINGTON</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		LENGTH OF STAY (in this place) <u>3 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASH. CO. HOSPITAL</u>		STREET ADDRESS <u>HAGERSTOWN MD. 12.3</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>HUBERT RUSSEL - LINE</u>				(Month) (Day) (Year) <u>FEB - 19 - 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 18 - 1901</u>	9. AGE last birthday <u>55-0-1</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if rejected) <u>BUS DRIVER - BOARD OF EDUCATION</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BREATHERSVILLE MD</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>CHARLES B. LINE</u>				14. MOTHER'S MAIDEN NAME <u>CORA M. CLARK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-4802</u>		17. INFORMANT & ADDRESS <u>MRS. LOUISE LINE HAGERSTOWN MD. 12.3</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						7 months	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cirrhosis of liver.</u>						7 months	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 9, 1955</u> , to <u>Feb. 19, 1956</u> , that I last saw the deceased alive on <u>Feb. 19, 1956</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Bell</u>		M. D.		ADDRESS (Street, city, town, state) <u>Hagerstown, Maryland.</u>		DATE SIGNED <u>Feb. 21, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Shash Boovera</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. F. BAST AND SONS</u>		ADDRESS <u>BOONSBORO MD</u>	
DATE <u>Feb. 22, 1956</u>							

INSTRUCTIONS

1 DR. BELL

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CHURCH

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF COFFIN MAKER

20. SIGNATURE OF CARRIER

21. SIGNATURE OF BURIAL

22. SIGNATURE OF INTERMENT

23. SIGNATURE OF CREMATION

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

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BUREAU V. S.

FEB 27 1956

RECEIVED

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INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2267

CERTIFICATE OF DEATH

02236

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>Rural, Hagerstown, Md.</u>				TOWN <u>Rural, Hagerstown, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Home</u>				STREET ADDRESS (If rural give location) <u>Williamsport Pike</u>			
3. NAME OF DECEASED (Type or Print) <u>Nellie M. Little</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 16 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>2-24-1872</u>	
9. AGE last birthday <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>0</u> Days <u>8</u>		Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guest at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Little</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Ellen McCammon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>H. K. Stickell, Hagerstown, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Heart Disease</u>						<u>3 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u></u>							
DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-10-1936</u>, to <u>2-16-1936</u>, that I last saw the deceased alive on <u>2-10-1936</u>, and that death occurred at <u></u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. K. Stickell</u> M.D.				ADDRESS (Street, city, town, state) <u>Hagerstown, Maryland</u>		DATE SIGNED <u>7/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-18-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb. 18, 1956</u>		REGISTRAR'S SIGNATURE <u>Blas H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Fun. Home, Hagerstown, Md.</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Usual Residence

7. Cause of Death

8. Date of Death

9. Time of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Health Officer

15. Signature of Burial Officer

16. Signature of Undertaker

17. Signature of Funeral Home

18. Signature of Cemetery

19. Signature of Interment

20. Signature of Burial

21. Signature of Burial

22. Signature of Burial

23. Signature of Burial

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BUREAU V. S.

FEB 21 1956

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RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2223 CERTIFICATE OF DEATH

02237

Reg. Dist. No. 307

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Washington</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Hagerstown</i>				TOWN <i>Holfersville</i>		<i>10x-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Wash. Co. Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Stella</i> (Middle) <i>M.</i> (Last) <i>Longman</i>				(Month) <i>2</i> (Day) <i>9</i> (Year) <i>1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>white</i>	<i>single</i>	<i>9-17-1884</i>	<i>71</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>housekeeper</i>		<i>own home</i>		<i>Maryland</i>		<i>U. S.</i>	
13. FATHER'S NAME				14. MOTHER'S MARDEN NAME			
<i>Joshua Longman</i>				<i>Martha Kline</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>none</i>		<i>Mrs. Norma Fletcher, Holfersville, Md.</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
154X IMMEDIATE CAUSE (A) <i>Massive Pulmonary Embolism</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Adenocarcinoma of Rectum</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>cholelithiasis</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<i>2/7/56</i>		<i>Adenocarcinoma of Rectum - Cholelithiasis</i>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/9</i> , 19 <i>56</i> , to <i>2/9</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>2/9</i> , 19 <i>56</i> , and that death occurred at <i>5:00P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Charles F. Nees</i>				ADDRESS (Street, city, town, state) <i>Smithsburg, Md.</i>			
M.D.				DATE SIGNED <i>2/10/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2-12-1956</i>		<i>Lutheran Cemetery</i>		<i>Holfersville, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Feb 15, 1956</i>		<i>Chas. Bowyer</i>		<i>Gladkill Co, Middletown, Md</i>			

It is a very fine
specimen of the
species.

1000
F. 1000

Stella M. Longman
1871-1874 P. 10-11

Maryland
M. L. L.

no. 10

Mr. James F. Smith, Secretary,
Winter House.
St. Louis, Mo.

BUREAU V. S.

FEB 15 1956

RECEIVED

Miss S. H. Ketchum, Secretary
Miss C. Ketchum, Treasurer

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02238

Item 21 Film G192 2-15-56
ams

2224

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>4 Days</u>		TOWN <u>Leitersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph H. Martin</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 3 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/23/1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Martin</u>				14. MOTHER'S MAIDEN NAME <u>Letha Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frank Z. Martin, Leitersburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Spontaneous Pneumothorax Rt.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Fractured Ribs Rt. 6-10</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Hemorrhage</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Grocery store</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Leitersburg Wash. Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>1-30-56 10 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Patient fell as a result of Cerebral Hemorrhage.</u>			
22. I hereby certify that I attended the deceased from <u>1/30</u>, 19<u>56</u>, to <u>2/3</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/2</u>, 19<u>56</u>, and that death occurred at <u>7:40 A.M.</u>, from the causes and on the date stated above.							
SIGNATURE <u>Charles E. Hess</u>				ADDRESS (Street, city, town, state) <u>Smithsburg, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Beaver Creek</u>		LOCATION (City, town, or county) (State) <u>Washington Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 6, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter Z. Grove</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Grove, Waynesboro Pa.</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed, this certificate should be filed with the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2225

CERTIFICATE OF DEATH

02239

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 MOS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 81 WASHINGTON CO. HOSP.		d. STREET ADDRESS 350 ANTIETAM DRIVE	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle IRENE Last MAYE		4. DATE OF DEATH Month FEB. Day 25 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1955
9. AGE (In years lost birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 8	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALLISON G. MAYE	
14. MOTHER'S MAIDEN NAME DORCAS TABLER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT EYDONNELLAN Address 131 W. WASHINGTON ST. HAGERSTOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA (c) CONGENITAL HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 12 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AS ABOVE			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. — p. m. — 19 56		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Jan 24 , 19 56 , to Feb 25 , 19 56 , that I last saw the deceased alive on Feb 25 , 19 56 , and that death occurred at 12:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 131 W. WASHINGTON ST. HAGERSTOWN, MD. DATE SIGNED 2/25/56			
ACTUAL SIGNATURE Elaine K Donnellan M.D.		PHYSICIAN'S NAME (Type) ELAINE K. DONNELLAN HAGERSTOWN, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/56	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Koment		24a. REC'D BY REGISTRAR Feb 28, 1956	
24b. REGISTRAR'S SIGNATURE Chas H Bowers			

2081273416

MAR 2 1956

RECEIVED

2226

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY WASHINGTON		MARYLAND		STATE MARYLAND		COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Hagerstown		LENGTH OF STAY (in this place) 9 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Williamsport			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital		STREET ADDRESS (If rural give location) 38 W. Church Street					
3. NAME OF DECEASED: (First) (Middle) (Last) Charles Edward Mills				4. DATE (Month) (Day) (Year) OF DEATH: Feb. 7 1956			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Sept. 18 1877	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months 4 Days 19	IF UNDER 24 HRS. Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: Airplane Factory		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles Mills				14. MOTHER'S MAIDEN NAME: Sallie Wine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No. 216-07-122		17. INFORMANT & ADDRESS: Church Street Mr. Hubert Mills Williamsport Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Apoplexy				7 Days			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/7/56 , 19 56 , to 2/7/56 , 19 56 , that I last saw the deceased alive on 2/7/56 , 19 56 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
SIGNATURE W. H. G. Young		M. D. W. H. G. Young		ADDRESS Williamsport Md.		DATE SIGNED 2/7/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 10-56		NAME OF CEMETERY OR CREMATORY Riverview Cemetery		LOCATION (City, town, or county) (State) Williamsport Md.	
DATE REC'D BY LOCAL REGISTRAR Feb. 9. 1956		REGISTRAR'S SIGNATURE W. H. G. Young		24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 14 1956
BUREAU V. S.

2227

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Big Pool, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co., Hospital</u>		STREET ADDRESS (If rural give location) <u>/</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Phillip L. Mills Jr.</u>		<u>FEBRUARY 25 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Feb. 25, 1956</u>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>None</u>		<u>None</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Hagerstown, Md.</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Phillip L. Mills</u>		<u>Pauline Mayhew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>None</u>			
17. INFORMANT & ADDRESS:			
<u>Phillip L. Mills - Big Pool, Md. R D</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>ERYTHROBLASTOSIS FOETALIS</u>			<u>4 HOURS</u>
ANTECEDENT CAUSE (B) <u>None</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>FEB 25, 19 56</u> to <u>FEB 25, 19 56</u> , that I last saw the deceased alive on <u>FEB 25, 19 56</u> , and that death occurred at <u>4-20 P.</u> from the causes and on the date stated above.			
SIGNATURE <u>Pauline Mayhew</u>		M. D. CLEAR SPRING, MARYLAND DATE SIGNED <u>FEBRUARY 26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb. 27, 1956</u>	<u>Park Head Cemetery</u>	<u>Near Clear Spring, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>FEB. 27, 1956</u>	<u>Charles H. Bowers</u>	<u>William H. Kauland</u>	<u>Clear Spring Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 29 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02242

2268 CERTIFICATE OF DEATH

Reg. Dist. No. 365

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>TILGHMANTON</u>		<u>LIFE</u>		<u>TILGHMANTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>TILGHMANTON MD.</u>				STREET ADDRESS (If rural give location) <u>TILGHMANTON MD</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
<u>DANIEL</u>		<u>W.</u>		<u>MOATS</u>		OF DEATH: <u>FEBRUARY 2 - 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>OCT. 17 - 1875</u>	<u>80-3-15</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>FARM</u>		11. BIRTHPLACE (State or foreign country): <u>TILGHMANTON WASH. Co. MD. U.S.A.</u>	
13. FATHER'S NAME: <u>FRISBY MOATS</u>				14. MOTHER'S MAIDEN NAME: <u>MAGGIE KNODLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>MRS. BLANCHE DAVIS TILGHMANTON MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 Coronary thrombosis</u>						<u>1 week.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive cardio-vascular disease</u>						<u>5 Yrs.</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>1950</u> , 19....., to <u>2/2/56</u> 19....., that I last saw the deceased alive on <u>2/1/56</u> , 19....., and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>M. D. Sharpsburg, Md.</u>		DATE SIGNED <u>2/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB-5-1956</u>		NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>		LOCATION (City, town, or county) (State) <u>TILGHMANTON WASH. Co. MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>FEB-4-1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>WM.F. BAST AND SONS</u>		ADDRESS <u>BOONSBORO MD</u>	

RECEIVED

FEB 8 1956

BUREAU V. S.

2228

MARYLAND STATE DEPARTMENT OF HEALTH

02243

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> STREET ADDRESS (If rural, give location) <u>Hagerstown Md. R.3</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Samuel</u> (Middle) <u>Edward</u> (Last) <u>Moats</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>9</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 18, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboren. M. J. Brown Construction Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65-1-21</u> yrs. If under 1 year: Months <u>1</u> Days <u>21</u> Hours <u>19</u> Mins. <u>56</u>
11. FATHER'S NAME <u>Charles B. Moats</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Anna Ripple</u>	
15. SOCIAL SECURITY NO. <u>213-18-8666</u>		16. INFORMANT AND ADDRESS <u>Mrs. Cora M. Moats Hagerstown Md. R.3</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>260x Arterio-sclerotic Heart Disease</u>		<u>24</u>
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>5 yr</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>A. E. W. Smith</u>	(Degree or title) <u>Med Exm</u>	ADDRESS <u>Hagerstown Md</u>	DATE SIGNED <u>7/14/56</u>
RITIAL CREMATION (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 12, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>	LOCATION (City, town, or county) (State) <u>near Beltsville Wash. Co. Md.</u>
DATE REC'D BY LOCAL <u>Feb. 11, 1956</u>	REGISTRAR'S SIGNATURE <u>Phyllis H. Powers</u>	24. FUNERAL DIRECTOR <u>Wm. F. Best & Sons</u>	ADDRESS <u>Boonsboro Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1955

BUREAU V. S.

MEDICAL CERTIFICATION

VS AIS (4)
15M 9/SS

RECEIVED

MAR 7 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02245

2230 **CERTIFICATE OF DEATH**

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>md.</u> COUNTY <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS		STREET ADDRESS	
<u>Washington County Hospital</u>		<u>24 hrs.</u>		<u>23 High St.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>EMZELLA A Moulden</u>				<u>2</u> <u>25</u> <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>2/28/1880</u>	
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Smith Co. Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew HACKETT</u>				14. MOTHER'S MAIDEN NAME <u>MARY Kinsley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-4881A</u>		17. INFORMANT & ADDRESS <u>23 High St. md. Hazel Moulden Hagerstown</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/24</u> , 19 <u>56</u> , to <u>2/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>56</u> , and that death occurred at <u>12:15</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Paul Harrison</u>		ADDRESS (Street, city, town, state) <u>318 N. Potomac Hagerstown md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 27, 1956</u>		REGISTRAR'S SIGNATURE <u>Charles Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc</u> ADDRESS <u>Wm. A. Wood U-Pros.</u>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Washington

MD

DATE OF DEATH

Washington

Washington

DATE OF DEATH

Washington

22 11 1956

Washington County Hospital

22 11 56

Emilia A. Moulder

Emilia A. Moulder

2/23/1956

Female White

Female White

Smith Co. Kansas

Female White

Mary Kinley

Andrew Mackett

23 11 56

214-04-481A Hotel Moulder Washington

No

BUREAU V. 2

FEB 29 1956

RECEIVED

State Health Department
Washington, D.C.
20540

MARYLAND STATE DEPARTMENT OF HEALTH

02246

2231

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>30 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>720 W. Church St</u>				STREET ADDRESS (If rural, give location) <u>720 W. Church St.</u>	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH
<u>LESSIE</u>		<u>Vanney</u>	<u>Moyer</u>	<u>2</u>	<u>7</u> 19 <u>56</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3/31/1891</u>	9. AGE last birthday <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Hunts, VA.</u>	
13. FATHER'S NAME <u>James Wm. McGUIRE</u>		14. MOTHER'S MAIDEN NAME <u>Laura B. Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Newton H. Moyer 720 W. Church St Hagerstown, Md</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	<u>Chr. glomerular nephritis</u>	<u>3 yrs</u>
Antecedent cause(s) (b)	<u>Vascular hypertension</u>	<u>8 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>Diabetes M</u>	<u>20 yrs</u>
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>1946</u>	19b. MAJOR FINDINGS OF OPERATION <u>Amputation lf leg low thigh - gangrene of foot</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY <u>none</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>-</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/10/56</u>	NAME OF CEMETERY OR CREMATORY <u>REST HAVEN Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REGISTRY <u>Feb. 9, 1956</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	24. FUNERAL DIRECTOR <u>REST HAVEN FUNERAL Chapel Inc.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

8 14 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02247

Dr. Bell

2232 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>8 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>723 South Potomac St.</u>			
3. NAME OF DECEASED (Type or Print) <u>HELEN</u> <u>MAE</u> <u>NUNAMAKER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 12,</u> <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 23, 1892</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Tilghmanton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William N. Rohrer</u>				14. MOTHER'S MAIDEN NAME <u>Martha E. Morrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Samuel R. Nunamaker</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 260X (B) <u>Diabetes Mellitus</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						2 years	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 12, 1956</u> , to <u>Feb. 12, 1956</u> , that I last saw the deceased alive on <u>Feb. 12, 1956</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ra Bell</u>		M.D. <u>Hagerstown, Maryland</u>		ADDRESS (Street, city, town, state) <u>Feb. 14, 1956</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb. 15, 1956</u>		REGISTRAR'S SIGNATURE <u>Phas H. Bower</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>		ADDRESS	

STATE CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 18

REG. NO. 100

NAME OF DECEASED

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

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BUREAU V. S.

FEB 17 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02248

2269 CERTIFICATE OF DEATH

Reg. Dist. No. 3 D 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural, Smithsburg</u>		<u>12 Yrs.</u>		OR TOWN <u>Rural, Smithsburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smithsburg #2</u>				STREET ADDRESS (If rural give location) <u>Smithsburg #2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>James</u> (Last) <u>Oden</u>				(Month) <u>Feb.</u> (Day) <u>11,</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Aug. 21, 1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		<u>Superlin Dairy</u>		<u>Waynesboro Pa.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Edward Oden</u>				<u>Addie Welty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mrs. N. Grace Oden, Smithsburg Md #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 mts.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Arteriosclerotic Heart</u>				<u>4 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 11, 1956</u> to <u>Feb. 11, 1956</u> , that I last saw the deceased alive on <u>Feb. 11, 1956</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. G. Oden</u>				DATE SIGNED <u>md</u>			
M.D. <u>Smithsburg</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>2/14/56</u>		<u>Stouffers</u>		<u>Washington Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb 13-56</u>		<u>Geo. H. Ferguson</u>		<u>Walter V. Grove, Waynesboro Pa.</u>			

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 304

2270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>W.Va</u>		COUNTY <u>Morgan</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>TOWN Hancock, Md R F D I</u>		<u>1 week</u>		<u>TOWN Near Great Cacapon</u>		<u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Webber Wesley Parlett</u>				<u>Feb. 7, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Jan. 5, 1884</u>	<u>72 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired Trackman B & O Railroad Buck Valley Pa.</u>						<u>USA</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
<u>USA</u>				<u>Thomas Parlett</u>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Jermima Divelbliss</u>				<u>No</u>			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
<u>236 -22- 5243</u>				<u>Cecil Parlett Great Cacapon, W.Va.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u>						<u>7 hrs. min.</u>	
Antecedent causes (s) (b) <u>Arteriosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Fracture left femur</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED (While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
OF INJURY		m.					
22. I hereby certify that I attended the deceased from <u>1-2</u> , 19 <u>56</u> to <u>2-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>56</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE (Degree or title)				DATE SIGNED			
<u>Hubert R. Thomas M.D.</u>				<u>2-8-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 10, 1956</u>		<u>Great Cacapon Cemetery</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/8/56</u>		<u>[Signature]</u>		<u>[Signature]</u>			

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 14 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02250

2233 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>4 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural give location) <u>Wash. Co. Home</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles Frederick Raupach</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 19 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>	8. DATE OF BIRTH: <u>May 22, 1876</u>
9. AGE last birthday <u>79 yrs.</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ret. Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Somerset Co. Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME: <u>Julia Shoemaker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>James Raupach, Cumberland, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>cerebral Hemorrhage with hemiplegia</u>			<u>72 hours</u>
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic Hypertensive Heart Disease</u>			<u>unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>none</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 1, 1955</u> , to <u>Feb. 18, 1956</u> that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>56</u> , and that death occurred at <u>10:50 PM</u> M, from the causes and on the date stated above. SIGNATURE <u>Charles Robert Cohen</u> ADDRESS <u>Clear Spring, Maryland</u> DATE SIGNED <u>Feb 19, 1956</u> M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>	DATE THEREOF <u>2-19-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 19, 1956</u>	REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	24. FUNERAL DIRECTOR ADDRESS <u>Hafer Funeral Home, Cumberland, Md.</u>	

RECEIVED

FEB 21 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02251

2234

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Penna.</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown Ind</u> LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Mercersburg</u> <u>751-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co Hospital</u>		STREET ADDRESS <u>R. D. 3</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>LEOYD</u> (Middle) <u>R.</u> (Last) <u>ROCKWELL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB.</u> <u>19,</u> <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 30-1894</u> 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumberman</u>	9. AGE last birthday <u>61</u> yrs.
11. FATHER'S NAME <u>Jacob Rockwell</u>		12. BIRTHPLACE (State or foreign country) <u>Pennsylvania Pa R D 3</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Susan Myers</u>	
15. SOCIAL SECURITY No. <u>180-26-7497</u>		16. INFORMANT AND ADDRESS <u>Loyd Rockwell, RA3 Box 108, Mercersburg Pa.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Adenocarcinoma of colon</u>		<u>1 year</u>
Antecedent cause(s) (b) _____		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>April, 1955</u>	19b. MAJOR FINDINGS OF OPERATION <u>Inoperable carcinoma of colon.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19....., to 2/19/56, 19....., that I last saw the deceased alive on 2/18/56, 19....., and that death occurred at 8:45 a.m., from the causes and on the date stated above.

SIGNATURE McBreen, H. H. ADDRESS Greencastle, Penna. DATE SIGNED 2/19/56

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 22-56</u>	NAME OF CEMETERY OR CREMATORY <u>Fair View Cemetery</u>	LOCATION (City, town, or county) (State) <u>Mercersburg Pa.</u>
DATE REC'D BY LOCAL <u>Feb. 20, 1956</u>	REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	24. FUNERAL DIRECTOR <u>M. L. Luning</u>	ADDRESS <u>Mercersburg, Pa.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 23 1956

RECEIVED

2271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg				c. LENGTH OF STAY IN 1b 32 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #2				d. STREET ADDRESS RFD #2			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Last Ross				4. DATE OF DEATH Month Feb. Day 23 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1880	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry H. Ross				14. MOTHER'S MAIDEN NAME Sarah Hause			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-16-2266		17. INFORMANT Address Alice S. Ross, Smithsburg, RFD 2, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 28 Hrs. 2 yrs.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/26, 1954 , to 2/23, 1956 , that I last saw the deceased alive on 2/23, 1956 , and that death occurred at 5:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. Hess				ADDRESS (Street, city or town, state) Smithsburg, Md.		DATE SIGNED 2/23/56	
PHYSICIAN'S NAME (Type) Charles F. Hess							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-26-56		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR DATE 2/24/56		24b. REGISTRAR'S SIGNATURE Geo. W. Ferguson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02253

2272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u>			c. LENGTH OF STAY IN 1b <u>58 Yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Julius</u> Last <u>Sciesse</u>				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1879</u>		9. AGE (In years lost birthday) <u>76</u> yrs. <u>9</u> Months <u>9</u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Orchard.</u>		11. BIRTHPLACE (State or foreign country) <u>Fulton County Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P Sciesse</u>				14. MOTHER'S MAIDEN NAME <u>Margarett Snipe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-7438</u>		17. INFORMANT <u>Mrs Kattie P Sciesse Rural 1 Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>NONE</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 8</u> , 19 <u>55</u> , to <u>FEB 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JANUARY 27</u> , 19 <u>56</u> , and that death occurred at <u>1-45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CLEAR SPRING, MD.</u> DATE SIGNED <u>FEB. 28, 1956</u> ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D. PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2.29.56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. L. L. Hancock Md</u>				24a. REC'D BY REGISTRAR <u>1/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Neller</u>	

BUREAU V. S.

MAR 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02254

2235

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 hours
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 15 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pennsylvania County Franklin
City or town Mercersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. N. MAIN ST
(If rural, give LOCATION)
2. (a) If veteran, name war 0

3. (a) FULL NAME

THERESA MORROW SHANK

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Charles F. Shank

7. Birth date of deceased (mo., day, yr.) Nov. 9 - 1898

6. (c) If alive, give age 65 years

8. AGE: Years Months Days If less than one day

57 3 18 hrs. min.

9. Birthplace Newburg Penna.

(town, county, and state)

10. Usual occupation House wife

11. Industry or business Own Home

12. Name John W. Morrow

13. Birthplace Newburg Pa.

14. Maiden name Lillie Belle Storch

15. Birthplace Newburg Pa.

16. Informant C. F. Shank

Address Mercersburg, Pa.

17. (Burial, cremation, or removal, Which?) Burial Date thereof 2/29/56

Cemetery or crematory Fairview Cemetery

Location Mercersburg Pa.

18. Funeral director J. M. Lamminger

Address Mercersburg, Pa.

19. (Date rec'd by registrar) Feb. 28, 56 Registrar Blair H. Bowser

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 19 56 at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 45 to 2-27 19 56 and that I last saw him/her alive on Feb. 27 19 56

Immediate cause of death Chronic rheumatic valvulitis with terminal congestive failure and acute cardiac dilatation

DURATION

Due to.....

Due to..... 114X

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE J. C. Bowser M. D. or other

Address Fairview Cemetery Date signed 2/27/56

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 2 1956

RECEIVED

2273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02255
Reg. Dist. 3 03

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 324

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Washington		MARYLAND		STATE Md.		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Clear Spring R2		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Clear Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) Route 2			
3. NAME OF DECEASED: (First) Jacob		(Middle) Oscar		(Last) Shaw		4. DATE OF DEATH: (Month) 2 (Day) 11 (Year) 19 56	
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married		8. DATE OF BIRTH: Sept. 18, 1897	
9. AGE last birthday: 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Trackman		11. BIRTHPLACE (State or foreign country): Mc Coys Ferry Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Jacob Shaw				14. MOTHER'S MAIDEN NAME: Rebecca Grooms			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: 220-10-3189		17. INFORMANT & ADDRESS: Mrs. Alfie Shaw Clear Spring, Md. R2			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) DUE TO Antecedent cause(s) (b) acute coronary Occlusion Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							5hrs.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY None M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE S. Robert Wells M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-16-11-56 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: 2-14-56		NAME OF CEMETERY OR CREMATORY: Shanktown		LOCATION (City, town, or county) (State): Big Spring Md.	
DATE REC'D BY LOCAL REG. Feb-14-1956		REGISTRAR'S SIGNATURE Joseph W. Murray		24. FUNERAL DIRECTOR ADDRESS: Adrian H. Rowland Clear Spring, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1956

BUREAU V. S.

2274

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Big Pool</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Big Pool</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Indian Springs</u>				STREET ADDRESS (If rural give location) <u>Indian Springs</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Gale Slayman</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feby. 22, 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jany. 24, 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Conductor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>W. M. R. R. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Warfordsburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>Lincoln Slayman</u>				14. MOTHER'S MAIDEN NAME: <u>Dorcas Dicken</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>705-10-5266</u>		17. INFORMANT & ADDRESS: <u>Mrs. Nellei Slayman-Big Pool, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>CORONARY ARTERY OCCLUSION, ACUTE</u>						5 MINUTES	
ANTECEDENT CAUSE (S) DUE TO (B) <u>ATHEROSCLEROSIS OF THE CORONARY ARTERIES</u>						11 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>NONE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u> NONE		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB. 22, 1956</u> , to <u>FEB. 22, 1956</u> , that I last saw the deceased DEAD on <u>FEB. 22, 1956</u> , and that death occurred at <u>5.55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paulie Robert Cohen</u>		M.D. <u>Paulie Robert Cohen</u>		ADDRESS <u>CLEAR SPRING, MARYLAND</u>		DATE SIGNED <u>FEB. 22, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feby. 25-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Clear Spring, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 25-1956</u>		REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>		24. FUNERAL DIRECTOR <u>William H. Rowland</u>		ADDRESS <u>Clear Spring Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 28 1956

RECEIVED

02257

MARYLAND

STATE DEPARTMENT OF HEALTH

2236

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASH. CO. HOSPITAL</u>		STREET ADDRESS <u>741 MARYLAND AVE.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELSIE ALBERTA SMITH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY-10-1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH-5-1900</u>
9. AGE last birthday <u>55-11-5</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>CHESTNUT GROVE WASH. CO. MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>CHARLES SMITH</u>	14. MOTHER'S MAIDEN NAME <u>ELLEN HOLMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO.</u>	16. SOCIAL SECURITY NO. <u>NO.</u>	17. INFORMANT AND ADDRESS <u>ALBERT L. SISK-741 MD. AVE. HAGERSTOWN MD</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
195X Immediate cause (a) <u>PULMONARY TUMOR MALIGNANT TYPE</u>		<u>14 YEARS</u>
Antecedent cause(s) <u>EMETASTASIS TO FEMUR AND SPINE</u>		<u>FEMUR 2 1/2 YRS</u> <u>SPINE 1 YEAR</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (a-b) <u>ADRENAL TUMOR, MALIGNANT TYPE</u>		<u>UNKNOWN</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG 1954 to FEB 10, 1956, that I last saw the deceased alive on FEB 10, 1956, and that death occurred at 3:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>FEB 14 1956</u>	NAME OF CEMETERY OR CREMATORY <u>SAMPLES MANOR CEMETERY</u>	LOCATION (City, town, or county) (State) <u>WASH. CO. MD</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>FEB 13 1956</u>	REGISTRAR'S SIGNATURE <u>Wm F. BAST</u>	24. FUNERAL DIRECTOR <u>Wm F. BAST AND SONS</u>	ADDRESS <u>BOONSBORO MD</u>

DR. WM LAYMAN
PROFESSIONAL ARTS BLDG.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 15 1956

RECEIVED

2237 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>03</u> TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>56</u> Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>03</u> <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17</u> <u>456 Guilford Ave.</u>		STREET ADDRESS (If rural give location) <u>456 Guilford Ave.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>ADA</u>	(Middle) <u>KATHERINE</u>	(Last) <u>STONER</u>	<u>February 13,</u> 19 <u>56</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>March 23, 1882</u>
9. AGE last birthday <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Rockdale, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry B. Leshner</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Ellen Stine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Earl L. Stoner Hagerstown, Maryland</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>420.0 Arterio sclerotic heart disease</u>			<u>3 yrs</u>
ANTECEDENT CAUSE (S) (B) <u>Hypertension</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterio sclerosis</u>			<u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>52</u> , to <u>13 Feb</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>13 Feb</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> PM, from the causes and on the date stated above.			
SIGNATURE <u>E. L. Stoner</u>		ADDRESS <u>Hagerstown, Md.</u>	
DATE SIGNED <u>2/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/15/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 14 1956</u>		REGISTRAR'S SIGNATURE <u>Phas Bowers</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Suter-Rouzer Funeral Home Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 16 1956

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

02259

2238

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garage in rear of 223 East Irvin Avenue</u>		STREET ADDRESS (If rural, give location) <u>223 East Irvin Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Esther</u> (Middle) <u>Lawder</u> (Last) <u>Stoner</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>11</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 19, 1906</u>
9. AGE last birthday <u>50</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>22</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harve de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Lawder, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Baldwin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-2109</u>	
17. INFORMANT AND ADDRESS <u>Harry Lawder, 111, Harve de Grace, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

9791
Immediate cause(a) Carbon Monoxide Poisoning (Exhaust from automobile)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

none

-

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Garage</u>	(CITY OR TOWN) <u>Hagerstown</u>	(COUNTY) <u>Washington</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb. 11 1956 9 P.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Connected exhaust pipe to interior of car</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. Robert D. Mullen M.D.

MEDICAL EXAM.

115 N. Potomac St- Hagerstown, Md. 2113-56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-14-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>	(State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Feb 13/1956</u>	24. FUNERAL DIRECTOR <u>Suter-Rouzer Funeral Home, Hagerstown, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 15 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02260

2275 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>WASHINGTON</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>SAN MAR</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAGERSTOWN</u> <u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FAHRNEY-KEEDY MEMORIAL HOME</u>		STREET ADDRESS (If rural give location) <u>461 - PARK PLACE</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>FEBRUARY - 5 - 1956</u>	
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>SEPT - 5 - 1869</u>	
9. AGE last birthday: <u>86-5-0</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>RETIRED FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country): <u>NEAR MYERSVILLE FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>HAMILTON STOTTEMYER</u>		14. MOTHER'S MAIDEN NAME: <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT & ADDRESS: <u>PAULS. STOTTEMYER HAGERSTOWN MD. R. 2</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>450.0 Unclerlyd arteriosclerosis -</u>		<u>5 yrs</u>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 12</u> , 1956, to <u>Feb 5</u> , 1956, that I last saw the deceased alive on <u>Feb 5</u> , 1956, and that death occurred at <u>5.50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>G. W. Lellan</u>		ADDRESS <u>M. D. Boonsboro</u> DATE SIGNED <u>2/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB 8 - 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>CHURCH OF THE BRETHREN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BEAVER CREEK MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 8 - 1956</u>		REGISTRAR'S SIGNATURE <u>John H. Beck</u>	
24. FUNERAL DIRECTOR <u>WM. F. BAST AND SONS</u>		ADDRESS <u>Boonsboro MD.</u>	

RECEIVED
FEB 16 1956
BUREAU V. 21

1
M
INSTRUCTIONS
1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2276

CERTIFICATE OF DEATH

02261

Dr. Ditto, Jr.

Reg. Dist. No. 301

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Williamsport</u>		<u>2 Yrs</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitorium</u>				STREET ADDRESS (If rural give location) <u>638 George St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALICE VIRGINIA SUMMERS</u>				<u>Feb. 19, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Aug. 11, 1869</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Pondsville, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Alexander Grove</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Sensenbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. C. Earl Summers</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Broncho Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 Wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Heart Disease</u>				<u>3 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-1-1933</u> , to <u>2-19-1938</u> , that I last saw the deceased alive on <u>2-16-1936</u> , and that death occurred at <u>2:04</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>A. W. Ditto</u>		M.D. <u>A. W. Ditto</u>		ADDRESS (Street, city, town, state) <u>Hagerstown, Maryland</u>		DATE SIGNED <u>2/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-21-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
DATE <u>Feb 22 1956</u>							

CERTIFICATE OF DEATH

105201

THIS CERTIFICATE

IS TO BE FILLED OUT BY THE REGISTRAR

OF THE DISTRICT

IN WHICH THE DEATH OCCURRED

AND TO BE RETURNED TO THE

STATE DEPARTMENT OF HEALTH

WITH THE BODY

FOR INTERMENT

IN A PUBLIC CEMETERY

OR IN A PRIVATE CEMETERY

APPROVED BY THE REGISTRAR

ON FEBRUARY 27, 1956

AT BALTIMORE, MARYLAND

DEATH OF

JOHN J. JONES

AGE 65

SEX MALE

RACE WHITE

DATE OF BIRTH

APRIL 1, 1891

PLACE OF BIRTH

BALTIMORE, MARYLAND

CAUSE OF DEATH

HEART DISEASE

INTERMENT IN

PUBLIC CEMETERY

AT BALTIMORE, MARYLAND

ON FEBRUARY 27, 1956

AT BALTIMORE, MARYLAND

DEATH OF

JOHN J. JONES

AGE 65

SEX MALE

RACE WHITE

DATE OF BIRTH

APRIL 1, 1891

PLACE OF BIRTH

BALTIMORE, MARYLAND

CAUSE OF DEATH

HEART DISEASE

INTERMENT IN

PUBLIC CEMETERY

BUREAU V. S.

FEB 27 1956

RECEIVED

EXHIBIT 100-100

100-100

2239 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>6 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>739 Virginia Avenue</u>		STREET ADDRESS (If rural give location) <u>739 Virginia Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles</u> <u>Markwood</u> <u>Swecker</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>17</u> <u>19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>6-23-1885</u>
9. AGE last birthday <u>70 yrs.</u>		IF UNDER 1 YEAR: Months <u>8</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Layout Man</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Sheet Metal Plant</u>	
11. BIRTHPLACE (State or foreign country): <u>Mossy Creek, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Swecker</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Skyles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-8449</u>	
17. INFORMANT & ADDRESS: <u>Mrs. C. M. Swecker, Hagerstown, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>coronary artery thrombosis</u>			
ANTECEDENT CAUSE (S) DUE TO <u>arterio sclerotic myocardial heart disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>advanced generalized vascular arteriosclerosis</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>-</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>---</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>June</u> , <u>1955</u> , to <u>Feb.</u> , <u>17, 1956</u> , that I last saw the deceased alive on <u>Feb 14</u> , <u>19 56</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. Robert Wells M.D.</u>		ADDRESS <u>M.D. 115 N. Potomac St- Hag. Md</u>	
DATE SIGNED <u>Feb 19 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-20-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 20 1956</u>		REGISTRAR'S SIGNATURE <u>Spash H. Howard</u>	
24. FUNERAL DIRECTOR <u>Suter-Rouzer, Fun. Home Hagerstown, Md.</u>		ADDRESS	

RECEIVED

FEB 23 1956

BUREAU V. S.

2240

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>W. Virginia</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>23</u> TOWN <u>Hagerstown</u>	<u>6 mos.</u>	TOWN <u>Keyser</u> <u>85 x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>310 West Howard Street</u>		STREET ADDRESS (If rural give location) <u>107 Virginia Street</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Margaretta</u> <u>Trenton</u>		DATE OF DEATH: <u>Feb.</u> <u>18</u> <u>19 56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>8-17-1870</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>85 yrs.</u>		Months <u>6</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Housework</u>		<u>Oakland, Maryland</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>UNKNOWN</u>		<u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>NONE</u>	
17. INFORMANT & ADDRESS:			
<u>Howard Trenton, Hagerstown, Maryland</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Thrombosis, Coronary</u>			<u>5 min</u>
DUE TO ANTECEDENT CAUSE (S) (B) <u>Mural Thrombosis</u>			<u>indf</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic heart disease</u>			<u>indf.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>No</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY <u>street, office bldg., etc.</u>	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
<u>Keyser, W. Va.</u>			
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
<u>2-18-1956</u>			
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>death</u> , that I last saw the deceased alive on <u>2-15</u> , 19 <u>56</u> , and that death occurred at <u>11:35 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Leadley M.D.</u>		ADDRESS <u>Hagerstown</u> DATE SIGNED <u>2-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Removal</u>		<u>2-18-1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Markwood Fun. Home</u>		<u>Keyser, W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>Feb 18, 1956</u>		<u>Suter -Rouzer Fun. Home, Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2241 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02264

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			c. LENGTH OF STAY IN 1b 52 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 03		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00 200 Mealey Parkway				d. STREET ADDRESS 200 Mealey Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle CHARLES Last TRIESLER, Sr.				4. DATE OF DEATH Month February Day 26 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 29, 1898	
				9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 3 Days 27	
						IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A.				10b. KIND OF BUSINESS OR INDUSTRY own buisness		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Christian G. Triesler				14. MOTHER'S MAIDEN NAME Sophia K. Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/> W.W. I				16. SOCIAL SECURITY NO. 162-10-4119		17. INFORMANT Mrs. Louise Triesler Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 10 min
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour o. m. p. m. --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) - (County) - (State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2-28-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles M. Rye ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Feb. 27, 1956		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		RESIDENCE		DATE OF DEATH	
SEX		AGE		TIME OF DEATH	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
EDUCATION		DISEASE		SYMPTOMS	
RELIGION		TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY TESTS		X-RAY		PATHOLOGICAL FINDINGS	
TOXICOLOGY		AUTOPSY		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION		OFFICE OF THE EXAMINER	

BUREAU V. S.

FEB 29 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

02265

2242 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Meadow Apts. #6D</u>		STREET ADDRESS (If rural, give location) <u>814 Greene St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Florence</u>	(Middle) <u>Catherine</u>	(Last) <u>Walver</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>26</u>	(Year) <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>APRIL 20 1870</u>
9. AGE last birthday <u>85</u> yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSHUA KIGHT</u>		14. MOTHER'S MAIDEN NAME <u>MARY MICHAELS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or NO known) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>JOHN BYER HAGERSTOWN, MD.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
<p>422.1 Immediate cause (a) <u>acute coronary thrombosis</u></p> <p>Antecedent cause(s) (b) <u>arterio sclerotic myocardial heart disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>D. Robert Wells M.D.</u>		DATE SIGNED <u>Feb. 26 '56</u>	
DEPUTY MEDICAL EXAM.			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>FEB 29 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>PHILOS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WESTERNPORT MD.</u>	
DATE REC'D BY LOCAL REGISTRY <u>FEB 26 1956</u>		REGISTER'S SIGNATURE <u>Charles Bowers</u>	
24. FUNERAL DIRECTOR <u>WILLIAM H. KIGHT</u>		ADDRESS <u>CUMBERLAND MD.</u>	

BUREAU V. S.

FEB 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2243

CERTIFICATE OF DEATH

02267

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>81 Washington County Hospital</u>		d. STREET ADDRESS <u>1030 Salem Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>AUGUSTUS</u> Middle <u>LEE</u> Last <u>WIEBEL</u>		4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 3, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood Pin Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lewis H. Wiebel</u>		14. MOTHER'S MAIDEN NAME <u>Matilda P. Coxon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-18214</u>	
17. INFORMANT <u>Mrs. Norma L. Wood</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterograde Cardiac Arrest</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/22/</u> , 19 <u>54</u> , to <u>2/23/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/22/</u> , 19 <u>56</u> , and that death occurred at <u>1:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		ADDRESS (Street, city or town, state) <u>136 N. Potomac Street, Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		DATE SIGNED <u>Feb 25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Crumpacker</u> ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Feb 25/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Blair Bowers</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2244

CERTIFICATE OF DEATH

02268

Dr. W. T. Layman

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hagerstown</u>		<u>14 yrs.</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>638 Highland Way</u>				STREET ADDRESS (If rural give location) <u>638 Highland Way</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>MARGARET</u> (Middle) <u>LUCY</u> (Last) <u>WILLIAMS</u>				Feb. 20, 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>June 25, 1888</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Milesburg, Penna.</u>		<u>USA</u>	
13. FATHER'S NAME <u>Frank T. Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Clyde</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mr. Edmond B. Williams</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 20, 19 56</u> , to <u>Feb. 20, 19 56</u> , that I last saw the deceased alive on <u>Feb. 20, 19 56</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. T. Layman, M.D.</u>				ADDRESS (Street, city, town, state) <u>Hagerstown, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-22-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb 23, 1956</u>		REGISTRAR'S SIGNATURE <u>Blanch Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	

BUREAU V. S.

FEB 27 1956

RECEIVED

1
I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the 27th day of February, 1956, at Baltimore, Maryland.

REGISTRAR OF DEATHS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2277 CERTIFICATE OF DEATH

02269

Reg. Dist. No. 353

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		STATE MARYLAND		COUNTY WASHINGTON			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN RURAL HAGERSTOWN		2 YRS.		TOWN HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS GATEWAY NURSING HOME				STREET ADDRESS (If rural give location) 309 S. POTOMAC ST.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ELMER		(Middle) ERIE		(Last) WINTERS		(Month) FEB. (Day) 17 (Year) 19 56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
MALE	WHITE	WIDOWED	4/12/1879	76 yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CABINET MAKER			10b. KIND OF BUSINESS RETIRED ORGAN WKS.			11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN S. WINTERS				14. MOTHER'S MAIDEN NAME CECILIA WOLFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) NO (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MISS GERALDINE WINTERS HAGERSTOWN MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
491X IMMEDIATE CAUSE (A) Bronchial Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arterial Sclerosis				10 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1954 , to Feb 17 1956 , that I last saw the deceased alive on Feb 17 1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE David R. Brewer M.D.				DATE SIGNED 2/18/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/20/56		NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		LOCATION (City, town, or county) HAGERSTOWN MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Leroy M. Fochler		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		ADDRESS Hagerstown Md.	
DATE Feb 20-56							

(Weber)

1956 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED: **JOHN S. WINTER**

DATE OF DEATH: **FEBRUARY 2, 1956**

PLACE OF DEATH: **AT HOME**

RESIDENCE: **300 S. POTOMAC ST., WASHINGTON, D.C.**

AGE: **72**

SEX: **MALE**

DATE OF BIRTH: **NOVEMBER 10, 1883**

PLACE OF BIRTH: **NEW YORK, N.Y.**

CAUSE OF DEATH: **HEART DISEASE**

DATE OF INTERMENT: **FEBRUARY 3, 1956**

PLACE OF INTERMENT: **GREENWICH CEMETERY, NEW YORK, N.Y.**

NAME OF FUNERAL HOME: **JOHN S. WINTER & SONS**

NAME OF PHYSICIAN: **DR. J. H. WINTER**

NAME OF NURSE: **MRS. J. H. WINTER**

NAME OF MINISTER: **REV. J. H. WINTER**

NAME OF CLERGYMAN: **REV. J. H. WINTER**

NAME OF CHURCH: **ST. JOHN'S CHURCH**

NAME OF CEMETERY: **GREENWICH CEMETERY**

NAME OF BURIAL PLACE: **GREENWICH CEMETERY**

NAME OF INTERMENT PLACE: **GREENWICH CEMETERY**

NAME OF FUNERAL HOME: **JOHN S. WINTER & SONS**

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NAME OF FUNERAL HOME: **JOHN S. WINTER & SONS**

NAME OF FUNERAL HOME: **JOHN S. WINTER & SONS**

BUREAU V. S.

FEB 27 1956

RECEIVED

2245 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAGERSTOWN</u>		<u>2 WEEKS</u>		TOWN <u>RURAL</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASH. CO. HOSPITAL</u>				STREET ADDRESS <u>HAGERSTOWN MD. R. 4</u>			
3. NAME OF DECEASED (Type or Print) <u>PHILLIP - LESTER - WOLFE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY - 19 - 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>DEC. 17 - 1893</u>	9. AGE last birthday <u>62-2-0</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>2</u>		11. BIRTHPLACE (State or foreign country) <u>FOXVILLE FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ANDREW WOLFE</u>				14. MOTHER'S MAIDEN NAME <u>BLANCHE BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>LAWRENCE L. WOLFE SHARPSBURG MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
519.1 IMMEDIATE CAUSE (A) <u>Broncho Pneumonia</u>				<u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pleurisy with Effusion</u>				<u>2 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatic Heart Dis</u>				<u>6 months</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 19 1956</u> to <u>Feb 19 1956</u> , that I last saw the deceased alive on <u>Feb 19 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David R. Brewer</u>				ADDRESS (Street, city, town, state) <u>Clear Spring Md.</u>		DATE SIGNED <u>2/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 23. 1956</u>		NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>FOXVILLE FRED. CO. MD</u>	
24. REC'D BY REGISTRAR <u>Feb. 23/1956</u>		REGISTRAR'S SIGNATURE <u>David R. Brewer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. F. BAST AND SONS</u>		ADDRESS <u>BOONSBORO MD.</u>	

VS A15C 1-55 10M

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1

DR. BREWER

CERTIFICATE OF DEATH

Form No. 10

DATE OF DEATH

NAME OF DECEASED	DATE OF BIRTH	SEX	RACE	EDUCATION	RELIGION	DATE OF DEATH	PLACE OF DEATH	Cause of Death

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death

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RECEIVED
FEB 27 1956
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02266

2246

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Md.				c. LENGTH OF STAY IN 1b 22 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 572 Pen Mar Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Fannie Alice Young				4. DATE OF DEATH Month 2 Day 25 Year 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1914		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Lancaster, Pa.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John Young				14. MOTHER'S MAIDEN NAME Nicely L. Bank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-30-9056		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 434.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Kyphosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Jan 14 57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 23, 1957 , to Feb 25, 1956 , that I last saw the deceased alive on Feb 25, 1956 , and that death occurred at 10:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sidney Noveston M.D. 2100 4th Ave NE 2-2256 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) SIDNEY NOVESTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-29-1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John B Watson Jr.				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE Feb 27 1956	
				24b. REGISTRAR'S SIGNATURE Chas H Bowers			

CERTIFICATE OF DEATH

1954

MAR 5 1956

BUREAU V. S.

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